IMPACT EVALUATION OF BEHAVIOUR INTERVENTION
ON ILLNESS BREEDING BEHAVIOUR

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U.P. HEALTH SYSTEMS DEVELOPMENT PROJECT
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PREFACE

A well developed system of medical services is very important for the society as it contributes positively towards the development of human capital. Good health, proper nutrition and educational achievements are not merely attributes which increase income of individuals and contribute positively towards economic growth, but are qualities desirable for the upliftment of both the individuals as well as the society as a whole.

Despite the persistent resource constraints the government has been striving at providing health services in the country. However, the state continues to lag behind other states and the national average when we look at indicators of health. Consequently the state faces a challenge in fighting various communicable and non-communicable diseases, malnutrition and other problem particularly in rural areas.

The U.P. Health Systems Development Project, Lucknow sponsored a project to address some of these issues. The study was undertaken by the Neuro Psychiatry Department of the KGMU in the districts of Barabanki, Gorakhpur and Muzaffarnagar to develop positive health seeking behaviour with the use of minimal human and capital resources and build a system to generate demand and awareness regarding health care.

Once the KGMU submitted its report the UPHSDP then asked the Giri Institute of Development Studies to evaluate the work done by the KGMU to know whether the work undertaken by them has achieved the desired results or not. We are therefore thankful to the UPHSDP in reposing faith in us and providing us financial support to conduct the study. We are thankful to Mrs. Shalini Prasad who was the Project Director while the study was formulated and initiated and to Mr. Shailesh Krishna the present Director who has joined UPHSDP only recently. We received complete support from Dr. C.K. Singhal and Mrs. Neena Shukla from the initial to the final stages of the study and, therefore, we wish to record our gratitude to them for their kind co-operation.

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CHAPTER I

BRIEF NOTE ABOUT THE STUDY

I.1 INTRODUCTION

Ever since the inception of planning in the country every successive plan has been allocating funds for providing improved medical facilities to its teeming millions. Even in the case of Uttar Pradesh the same holds true. From a modest allocation of Rs.13.03 crore during the First Five Year Plan the State Government has allocated Rs.2405.43 crore during the Tenth Plan. The State has a high rural population and so we have a four-tier system of medical services. At the lowest level is the sub-health centre and is followed by the Primary Health Centre (PHC) and the Community Health Centre (CHC). At the apex is the district hospital. As a result of these investments in health services there have been improvements in some key indicators of health such as birth rate which has gone down from 44.9 per thousand in 1971 to 31.6 in 2001. Similarly death rate has declined from 20.1 to 1971 to 9.7 in 2001. Consequently the expectancy of life has gone up from 49.0 year during 1971 to 63.8 years by 2001. However, in spite of these developments, U.P. continues to remain below the national average in terms of the indicators of health and the state faces a challenge in fighting various communicable and non-communicable diseases, malnutrition and other problems particularly in rural areas where access to medical care facilities remains an issue.

The U.P. Health Systems Development Project therefore sponsored a pilot project in order to address these issues related to public health. This study was undertaken by the Neuro Psychiatry Department of KGMU in the districts of Barabanki, Gorakhpur and Muzaffarnagar to develop positive health seeking behaviour with the use of minimal human and capital resources and build a system to generate demand and awareness regarding health care.

The KGMU team undertook the task of behaviour intervention in 500 rural households covering five villages and 500 urban households covering five '*mohallas*" in Barabanki district. In the case of Gorakhpur and Muzaffarnagar only 25 households each were selected in rural and urban areas of each district. The duration of their study was 18 months.

Once the report was submitted by the KGMU team the U.P. Health Systems Development Project was keen to know whether the work undertaken by them had achieved the desired results or not. It was for this reason that they entrusted the task of evaluating the study to the Giri Institute of Development Studies, Lucknow. The study had the following objectives.

I.2 OBJECTIVES OF THE STUDY

(i) To find out the changes in morbidity of acute illness;

(ii) To find the degree of satisfaction in the community;

(iii) To find out the acceptability of the behaviour intervention package by the community; and

(iv) To find out the cost effectiveness of the study.

I.3 SAMPLE SIZE AND METHODOLOGY

The study was based on a survey of 50 per cent of the households selected by the KGMU for behaviour intervention (The Control Group). Besides this it was also proposed to carry out a survey of the uncontrolled group as well from each district. Therefore, the total sample which was to be covered is indicated below:

Table I.1: **Details of the Proposed Samples**

District	Rural Households	Urban Households	Total
Barabanki:			
(i) Control Group	125	125	250
(ii) Uncontrolled Group	50	50	100
Gorakhpur:			
(i) Control Group	15	15	30
(ii) Uncontrolled Group	10	10	20
Muzaffarnagar:			
(i) Control Group	15	15	30
(ii) Uncontrolled Group	10	10	20
Total:			
(i) Control Group	155	155	310
(ii) Uncontrolled Group	70	70	140

Besides survey of the controlled and uncontrolled groups the study had also proposed to survey all the interns who had been selected by the KGMU team and also some influential persons or NGOs from the area where behaviour intervention had been carried out by the KGMU team.

I.4 TOOLS

The survey was carried out with the help of structured schedules prepared separately for the controlled and uncontrolled groups and for the interns in order to obtain informations covering all aspects of the behaviour intervention package.

For obtaining information from the influential person and NGOs it was decided to have focussed group discussions with Gram Pradhan, NGO, PHC doctor, etc.

I.5 ACTUAL SAMPLE COVERED

(a) Control and Uncontrolled Group

The KGMU had covered 100 households each from five-selected villages of Barabanki representing the rural area and 100 households from five mohallas representing the urban areas of the district. For the purpose of our evaluation we took 25 households from each selected location from both rural and urban areas of Barabanki.

In the case of Gorakhpur and Muzaffarnagar the KGMU selected a sample of only 25 households from one village and 25 households from one urban mohalla from each of these districts. We had proposed to survey at least 15 households from each location and in each district.

Besides the controlled group it was also decided to select a sample of 10 households from rural location and urban location in each of our selected districts.

Thus the actual sample covered by us is being indicated in Table-1.2.

Table I.2: **Actual Sample Covered- Controlled and Uncontrolled Group**

District	Controlled Group	Uncontrolled Group
1. Barabanki (Rural)	125	50
(a) Harakh	25	10
(b) Israuliseth	25	10
(c) Abahipur	25	10
(d) Ibrahimabad	25	10
(e) Mohana	25	10
Barabanki (Urban)	125	50
(a) Balmiki Nagar	25	10
(b) Lakhpedabagh	25	10
(c) Durgapuri	25	10
(d) Satya Premi Nagar	25	10
(e) Peerbatawan	25	10
2. Gorakhpur		
(i) Rural-Araji Chauri	21	10
(ii) Urban-Humayunpur	16	10
3. Muzaffarnagar		
(i) Rural - Pachenda Kala	16	10
(ii) Urban - Brahmpuri	15	10
Total Sample	**318**	**140**
Rural	162	70
Urban	156	70

(b) Interns interviewed for the purpose of the study

The KGMU had selected people from the rural and urban localities to function as community interns. They were to facilitate in carrying out the intervention work in the selected districts. Around four interns were selected in each location and we covered all of them. The actual numbers contacted are shown in Table 1.3.

Table I.3: **Number of interns surveyed in each district**

District	No. of Interns
1. Barabanki (Rural)	23
(a) Harakh	5
(b) Israuliseth	5
(c) Abahipur	4
(d) Ibrahimabad	4
(e) Mohana	5
Barabanki (Urban)	22
(a) Balmikinagar	5
(b) Lakhpedebagh	5
(c) Durgapuri	4
(d) Satya Premi Nagar	5
(e) Peer batawan	3
2. Gorakhpur	
(a) Rural-Araji Chauri	4
(b) Urban-Humayunpur	2
3. Muzaffarnagar	
(a) Rural-Pachenda Kala	1
(b) Urban - Brahmpuri	1

(c) Discussion with some influential persons/NGO's regarding the intervention

Besides the survey of the controlled group, the uncontrolled group and the interns we also had discussions with a few influential persons like the Village Pradhan, active NGO, counsellors or the staff at the PHC to obtain their views regarding the intervention programme carried out by the KGMU in Barabanki. The number of such persons with whom we held discussion included four persons from the rural areas and three from urban areas respectively. In the case of Gorakhpur the Village Pradhan expressed hi ignorance about the scheme. The Pradhan of the village in Muzaffarnagar could not be contacted but his brother informed that the KGMU team had visited the village once and had contacted a few individuals.

This sums up the sample which we covered during the study.

I.6 BEHAVIOUR INTERVENTION IN MUZAFFARNAGAR DISTRICT

While our survey confirmed that the KGMU team had worked in the districts of Barabanki and Gorakhpur, there was no work done in Muzaffarnagar neither in the village of Pachenda Kala nor in the urban locality of Brahmpuri as indicated by the KGMU.

Brahmpuri is.a relatively posh locality of Muzaffarnagar and three members of the KGMU team met Dr. Ranjit Singh who, besides being a qualified doctor, is also running a NGO "Lok Kalyan Sewi Samiti". Dr. Ranjit has informed that they contacted him on two days and simply enquired from him about some other suitable individuals who could be made interns. The names of Dr. Harbeer Singh and Mr. Mohammad Rafiq were suggested by Dr. Ranjit. However, the KGMU team did not contact them at all as reported by Dr. Harbeer Singh. Dr. Ranjit Singh

was also requested by the KGMU team to invite some individuals living in the vicinity of the Doctor's residence. These are some of the names, which figure in the KGMU list of contact group members. However no discussion regarding the intervention was held with these individuals.

The KGMU team asked Dr. Ranjit to get a board painted indicating the health club. They also gave him eight posters and promised to return soon so that intervention work could be initiated. However neither did they pay towards the cost of getting board painted nor did they return as promised by them. Consequently, no work was done in the locality of Brahmpuri.

As for the village of Pachenda Kala is concerned it is on the outskirts of Muzaffarnagar city at a distance of around 6 kilometres. A total of five members visited the village and met the ex-Pradhan and asked him to collect a few villagers so that they could talk to them. The team spent barely a couple of hours in the village and gave them a general lecture regarding cleanliness etc. Those who had gathered were included in the list of contract group members as well as interns. However, except for one individual Shri Satyendra Kumar the other interns were not even informed that they were being selected for this work or the type of work, which was expected of them. The team promised to return to the village with other doctors to create awareness among people related to health care. The team did not make a second visit to the village.

We contracted 16 people in the village who have been listed among the selected beneficiaries and they confirmed that the KGMU team did not contact them. Similarly we met 15 beneficiaries from the list indicated by KGMU in the urban locality and they also confirmed that no one from KGMU or interns visited them.

To verify the same we also interviewed 10 members each from rural and urban locations representing the uncontrolled group and they too knew nothing about any work done by the KGMU.

Since the KGMU did not do any work in the district, no analysis has been done by us for Muzaffarnagar and the focus of the study are the districts of Barabanki and Gorakhpur.

CHAPTER II

IMPACT OF THE INTERVENTION ON CONTROL GROUP

In the previous chapter we have discussed in brief about the study, its methodology and sample size, etc. This chapter proposes to deal with the controlled group members who were beneficiaries of the intervention carried out by the team of doctors from the KGMU. We shall indicate the socio-economic background of these individuals and the impact and perception which resulted from the work carried out by KGMU in the districts of Barabanki and Gorakhpur.

II.1 SOCIO-ECONOMIC BACKGROUND OF THE BENEFICIARIES

As has been already indicated, the intervention was carried out in five villages and five urban mohallas of Barabanki and only one village and one urban mohalla from Gorakhpur. The sample covered by us included 125 beneficiaries from rural and urban areas respectively in Barabanki and 21 and 16 beneficiaries each from the rural and urban areas respectively in the case of Gorakhpur. The socio-economic background of the selected beneficiaries is given in Table 2.1.

In the rural areas of Barabanki the beneficiaries were concentrated in the age group 25-45 years and 45-60 years since around 37 and 39 per cent of our total sample was found concentrated in these two age groups. The pattern in the five villages follows a similar pattern. As far as the urban area is concerned the maximum concentration is in the 45-60 years age group since this group alone accounts for almost 50 per cent of the total sample. Even in the case of Gorakhpur maximum concentration was found in the 45-60 years age group in the rural areas. However, in the urban area the beneficiaries are not concentrated in any specific age group.

From the point of view of caste-wise distribution our sample from rural areas was heavily concentrated in the OBC category (around 55 per cent). At the village level the exceptions were Ibrahimabad and Mohana where the general caste population were relatively higher. Contrary to this the general caste was the dominant category in the urban areas in Barabanki with a total sample of around 46 per cent. At the level of individual mohallas, however, there were some variations In Balmikinagar and Satyapremi Nagar the SC/ST category was the dominant caste while the OBC families were in greater proportion in Peerbatawan. In both rural and urban areas of Gorakhpur most of the beneficiaries were from the general caste.

Looking at the educational level of the beneficiaries it was encouraging to note that illiterates were relatively few in number. Less than 20 per cent from rural and barely 10 per cent in the urban areas were found illiterate. In the rural areas the concentration was found among those who had studied upto Class VIII (42 per cent). Nearly 30 per cent had an educational qualification upto Intermediate level. If we look at the data on the village-wise basis a similar trend is observed. In the case of the urban areas those who are educated are almost evenly distributed between the different levels of education. Around one-third were graduates or above. Even in the case of Gorakhpur a similar trend was observed.

Table 2.1: **General Information from rural and urban household of Barabanki and Gorakhpur Districts (Control Group)**

Characteristics	Barabanki												Gorakhpur	
	Rural						Urban						Rural	Urban
	1	2	3	4	5	Total	1	2	3	4	5	Total	1	1
Actual Sample	25	25	25	25	25	125(100.0)	25	25	25	25	25	125(100.0)	21	16
1. Age-Group):														
Below 25 years	–	–	–	–	1	1(0.07)	–	–	–	–	1	1(0.07)	–	–
25 — 45 years	7	13	7	9	10	46(36.8)	7	9	7	4	8	35(18.0)	1	7
45 — 60 years	13	8	6	15	7	49(39.2)	13	14	9	18	8	62(49.7)	14	5
Above 60 years	5	4	12	1	7	29(21.3)	5	2	9	3	8	27(21.6)	6	4
2.Caste-wise:														
General	2	1	2	9	12	26(20.8)	7	23	12	9	6	57(45.6)	13	11
SC/ST	20	22	13	8	6	69(55.2)	2	2	3	3	11	21(16.8)	8	–
OBC	3	2	10	6	6	27(21.6)	13	–	2	13	–	28(22.8)	–	5
Minority	–	–	–	2	1	3(2.4)	3	–	8	–	8	19(15.2)	–	–
3.Educational Qualification:														
Illiterate	2	7	8	6	1	24(19.2)	4	–	2	2	4	12(9.6)	1	2
Upto Class VIII	10	11	12	8	12	53(42.4)	14	4	5	6	6	35(28.0)	13	3
High School/Intermediate	8	7	3	10	9	37(29.6)	1	13	4	6	11	35(28.0)	6	7
Graduate and above	5	–	2	1	3	11(8.8)	6	8	14	11	4	43(34.4)	1	4
4. Average size of Households	6.84	6.68	7.64	6.52	6.92	6.94	6.80	6.60	6.00	6.35	7.08	6.58	8.33	6.38
5.Income Category:														
Low	7	11	9	9	7	43(34.4)	6	–	8	9	5	28(22.4)	3	4
Medium	8	8	10	8	10	44(35.2)	11	12	8	8	12	51(40.8)	13	6
High	10	6	6	8	8	38(30.4)	8	13	9	8	8	46(36.8)	5	6
6. Average income of respondent	49360	40992	41540	66080	42932	48181	56822	85040	127000	73260	65239	82148	57714	55812
7. Average income of the household	71380	48472	55840	67520	65172	61677	78444	108240	139360	77620	83380	97409	72857	78281

N.B.: In Barabanki, the names of villages and urban localities are as follows:

Rural – 1. Harakh; 2. Israuliseth; 3. Abahipur; 4. Ibrahimabad ; 5. Mohana.

Urban- 1. Balmikinagar; 2. Lakhpedebagh; 3. Durgapuri ; 4. Satya Premi Nagar ; 5. Peerbatawan

In Gorakhpur

Rural – 1. Araji Chauri

Urban- 1. Humayunpur

P.S.: In all the other tables the villages and 'mohallas' have been given in the same sequence.

The average size of the household was close to 7 in the rural areas of Barabanki while in the urban areas it was around 6.5. In Gorakhpur, however, the size of the household was above 8 in the rural areas but was only around 6.5 in the urban areas.

We made an effort include in our sample people belonging to low, medium and high income categories. While in the rural areas we were able to distribute the sample almost evenly in the three categories, it was not easy to find people from the low income category in the urban areas and so a relatively higher share of the total sample is represented by the middle and higher income categories in the case of Barabanki. In Gorakhpur, while we had an almost even distribution in the urban area, our sample in the rural area was mainly concentrated in the middle income category. The overall average household income in rural Barabanki worked out to around Rs.62 thousand per annum whereas in the urban areas it was Rs.97 thousand. There were, of course, variations in the income between different villages and between different urban locations (Table 2.1).

II.2 INTERVENTION CARRIED OUT BY THE KGMU TEAM

In order to obtain the information about the work carried out by the KGMU team related to behaviour intervention we had asked the beneficiaries various questions related to the type of work done by the team, what aspects of health care etc. were discussed by them, and the number of team members and the frequency of their visits, etc. These details have been tabulated and are being presented in Table 2.2.

The response has been unanimous from both districts that the KGMU team did visit their districts covering both rural and urban areas. In terms of making people aware related to aspects of daily living it seems that the primary focus of the team was to inculcate the habit of general cleanliness and in maintaining a systematic daily routine in the rural areas. This is being felt because even after a time gap of almost two years nearly 90 per cent and 67 per cent respondents recall these two aspects on which the KGMU had laid stress. Their recollection regarding the other aspects of daily living such as regular exercise, need for proper ventilation, potable water and the need to have a harmonious atmosphere in the house where elders are respected and cared for are the aspects remembered by for fewer respondents. In the urban areas, however, the response levels were high with almost every aspect of daily living. A possible reason for this could be the fact that in the urban areas the people were relatively more educated and so already aware of these aspects even before the KGMU team embarked on their task of behaviour intervention. In Gorakhpur, on the other hand, the respondents from both rural and urban areas recollect with relative ease the fact that the KGMU laid stress mainly on cleanliness.

Table 2.2: **Details about the KGMU Intervention (Control Group)**

Details	Barabanki												Gorakhpur	
	Rural						Urban						Rural	Urban
	1	2	3	4	5	Total	1	2	3	4	5	Total	1	1
1. Did the KGMU Team visit your home:														
Yes	25	25	25	25	25	125	25	24	25	25	25	124	21	16
No	–	–	–	–	–	–	–	1	–	–	–	1	–	–
2. Aspects of daily living which were discussed:														
Cleanliness	23	22	21	22	24	112(89.6)	19	20	23	20	21	103(82.4)	13(61.9)	12(75.0)
Proper daily routing	15	16	18	16	19	84(67.2)	20	18	22	21	17	98(78.4)	8(38.1)	2(12.5)
Proper ventilation	15	9	10	7	8	49(39.2)	15	16	17	15	18	81(64.8)	–	–
Regular exercises	5	6	8	15	9	43(34.4)	18	12	18	12	15	75(60.0)	6(28.6)	4(25.0)
Need for potable water	3	10	6	8	14	41(32.8)	20	18	16	19	23	96(76.8)	7(33.3)	8(50.0)
Care of Elders	4	3	2	3	5	17(13.6)	21	17	20	22	24	104(83.2)	–	4(25.0)
Harmonious atmosphere	7	8	5	6	5	31(24.8)	22	20	18	20	17	97(77.6)	–	2(12.5)
3. Aspects of Health Care which were discussed:														
Treatment only from qualified doctors	18	16	23	16	12	85(68.0)	16	20	17	18	24	95(76.0)	11(52.4)	11(68.8)
Immediate treatment	9	10	12	15	17	63(50.4)	21	22	19	18	18	98(78.4)	3(14.3)	4(25.0)
Knowledge of seasonal illness	9	9	7	5	15	45(36.0)	19	21	18	17	19	94(75.2)	–	4(25.0)
Say No to superstitions	6	2	3	5	4	20(16.0)	18	19	17	16	18	88(70.4)	–	2(12.5)
Aware from addiction	10	6	3	2	6	27(21.4)	18	20	15	18	18	89(71.2)	–	3(18.7)
Avoid tension	5	4	8	5	3	25(20.0)	19	22	18	17	16	92(73.6)	–	2(12.5)
Family planning	4	3	4	3	5	19(15.2)	18	22	17	15	19	91(72.8)	–	–
Knowledge of AIDS	2	3	2	3	8	18(14.4)	11	18	13	10	15	67(53.6)	–	–
4. Aspects of Health Promotion which were discussed:														
Relevance of proper balanced diet	22	21	20	14	21	98(78.4)	19	20	17	18	21	95(76.0)	9(42.9)	8(50.0)
Eat fresh food only	10	4	6	8	12	40(32.0)	8	12	7	10	16	53(42.4)	8(38.1)	4(25.0)
Vaccination/Inoculation	3	7	3	4	7	24(19.2)	10	20	19	19	17	85(68.0)	2(9.5)	–
Cook vegetables in iron cauldron	4	3	2	4	5	18(14.4)	4	8	6	8	9	35(28.0)	–	–
5. How many members were there in the KGMU Team:														
Upto 4	12	14	2	1	15	44(35.2)	3	6	16	14	18	57(45.6)	7(33.3)	2(12.5)
5 — 6	5	10	5	9	8	37(29.6)	14	14	8	4	6	46(36.8)	14(66.7)	14(87.5)
7 — 8	2	–	3	6	1	12(9.6)	3	3	1	6	1	14(11.2)	–	–
9 and above	6	1	15	9	1	32(25.6)	5	2	–	1	–	8(6.4)	–	–
6. How many visits did they make of your house:														
1 — 2	8	2	1	7	4	22(17.6)	5	9	4	1	11	30(24.0)	12(57.1)	1(6.2)
3 — 4	11	12	12	11	12	58(46.4)	15	14	11	15	14	69(55.4)	9(42.9)	14(87.5)
Many	6	11	12	7	9	45(36.0)	5	2	10	9	–	26(20.8)	–	1(6.2)

There were eight areas in the field of health care which were taken up during the behaviour intervention but the only two aspects which have retained in the memory of the rural respondents are that treatment should always be taken from a qualified doctor (68 per cent responses) and that on falling ill treatment must be given immediately (50 per cent responses). It is these two aspects which are most crucial among the list of eight in this group and so it is to the credit of the KGMU team that people have remembered this advice. Moreover, in the prevailing atmosphere of the rural areas it will take quite an effort to make an impact on people regarding aspects such as staying away from all types of addition, from superstitions, etc. Contrary to this almost three-fourth of the respondents remember that the KGMU team discussed all the eight aspects of health care The response was low only with respect to knowledge regarding AIDS. Once again the response received from both rural and urban areas of Gorakhpur indicated that the only aspect about which they can recollect is that treatment should always be taken from a proper qualified doctor alone.

The third aspect of behaviour intervention was to promote health education among the control group households selected by the KGMU team in the two districts. There were four main areas which the team wanted to stress on and they were – relevance of balanced diet, that people should eat only fresh food and to retain an iron rich diet should cook food in an iron cauldron, and to get themselves and their children vaccinated and inoculated on a regular basis. The rural areas of Barabanki have followed the same pattern as in case of daily living and health care by responding that they mainly remember the KGMU team laying stress on balanced diet. Even in the urban areas this was the case as we received a positive response from around three-fourth of the sample covered by us. In the rural area of Gorakhpur the respondents remember having been informed about relevance of balanced diet as well as of fresh food. In the urban area however people mainly remember that the KGMU laid emphasis on having a proper balanced diet. In fact out of the 16 respondents four did not even remember any aspect of health promotion which the KGMU had listed.

The KGMU team had itself indicated that their team would comprise of a total of 6 members including two doctors, a psychologist, two social anthropologist/social worker and a field attendant. We tried to find out the total number of individuals who visited their village or mohalla from the KGMU. Of course, no one could say how many of them were doctors or with other qualifications as since all they knew was that a team of doctors had come to their area from the KGMU. Most people from the rural areas recollected that between 4 to 6 persons had visited their villages since the total response to this effect was around 65 per cent. The rest indicated that even a larger contingent had come to their villages. Similarly in the urban localities around 82 per cent respondents have reported that the KGMU team comprised of 4-6

members. In the case of Gorakhpur all respondents from rural as well as urban areas confirmed that 4-6 members had come to their area. From both rural and urban areas the maximum number of respondents revealed that this team paid 3-4 visits in their area. A similar picture is found in the case of Gorakhpur as well (Table 2.2).

When we compare the responses received from the villages and urban localities individually in the case of Barabanki it is observed that they follow a similar pattern obtained in the rural areas or the urban areas as a whole. There are, of course, some variations to be found and that is only understandable. It may therefore be said that whether we looked at responses related to the KGMU discussions in the areas of daily living, health care or health protection neither are wide fluctuations found among the five villages or the five urban localities. A similar pattern emerges even with respect to people's recollection about the composition of the team which worked in their area as well as the number of visits made by the team.

II.3 RESONDNET'S VIEW REGARDING THE INTERNS AND HEALTH CLUBS

To assist them in the task of behaviour intervention the KGMU team selected interns from each village and urban locality which was selected by them. We, therefore, thought it appropriate to enquire from our sample about the duties of these interns, the regularity with which they contacted the control group members, about the health clubs and its activities. All these aspects are being discussed with the help of Table 2.3.

Except for only a handful of the respondents, all were aware of the fact that the KGMU had selected individuals from their area to function as interns. This was true in all the villages and urban localities of Barabanki. The only exception was Harakh village where around one-fourth of the sample expressed their ignorance about interns. Surprisingly, the number of such individuals was found in sizeable number in both rural and urban areas of Gorakhpur. In fact the proportion of those not aware in urban areas exceeded those who are aware that interns had been appointed.

According to the respondents the main role of interns was to provide health related information. Almost 70 per cent respondents from rural areas of Barabanki and around 43 per cent from the urban areas of the same district. The interns were also expected to perform some other duties such as maintain regular contact with the members of the control group, make assessment of the impact of intervention and also to assist the control group members in case anyone falls ill. With respect to the respondents the response related to these responsibilities was much lower in the case of Barabanki. However, in Gorakhpur there was no response at all.

Table 2.3: **Respondents' View Regarding Interns and Health Clubs (Control Group)**

Details	Barabanki												Gorakhpur	
	Rural						Urban						Rural	Urban
	1	2	3	4	5	Total	1	2	3	4	5	Total	1	1
1. Are you aware that KGMU had appointed Interns:														
Yes	19	25	25	23	25	117(93.8)	25	23	25	25	25	123(98.4)	14	6
No	6	–	–	2	–	8(6.4)	---	2	–	–	–	2(1.6)	7	10
2. Role of the Interns														
(a) Provide health related information	15	20	21	19	12	87(69.6)	12	10	14	8	10	54(43.7)	14	6
(b) Maintain contact with control group members	8	11	6	14	7	46(36.8)	12	9	8	8	10	47(37.6)	–	–
(c) Assess the impact of intervention	5	3	4	3	6	21(16.8)	9	7	8	5	5	34(22.7)	–	–
(d) Help the controlled group in case of illness	–	–	2	7	3	12(9.6)	8	7	9	8	8	40(32.0)	–	–
3. How regularly did interns meet you:														
(a) Daily	–	1	–	2	–	3(2.6)	--	–	2	4	–	6(4.9)	–	–
(b) Weekly	12	14	11	13	15	65(55.5)	11	4	22	20	4	61(49.6)	–	–
(c) Once a month	7	10	13	7	9	46(39.3)	14	13	1	1	19	48(39.0)	–	1
(d) Rarely	–	–	1	1	1	3(2.6)	--	6	–	–	2	8(6.5)	14	5
4. Are you aware that KGMU formed health club:														
(a) Yes	17	25	16	12	22	92(73.6)	25	22	25	25	25	122(98.4)	–	6
(b) No	8	–	9	13	3	33(26.4)	--	3	–	–	–	3(1.6)	21	10
5. If Yes, what were its activities?														
(a) The interns discussed their problems	6	15	5	4	10	40(43.5)	8	6	12	4	5	35(28.4)	–	3
(b) Discuss how health awareness can be spread	6	8	2	2	10	28(30.4)	10	3	10	21	13	57(46.3)	–	3
(c) No specific knowledge	5	2	9	6	2	24(26.1)	7	13	3	–	7	30(24.4)	–	–
6. Frequency of health club meetings:														
(a) Once a week	1	8	4	2	3	18(19.6)	6	–	12	9	–	27(21.9)_	–	–
(b) Occasionally	14	8	7	3	11	43(46.7)	9	5	10	16	18	58(47.1)	–	–
(c)Once in a month	2	5	2	5	4	18(19.6)	3	7	–	–	–	10(8.1)	–	6
(d) No knowledge	–	4	3	2	4	13(14.1)	7	10	3	–	7	27(21.9)	–	–
7. Did you also visit the Health Club?														
(a) Regularly	1	6	1	–	4	12(13.1)	5	2	–	–	1	8(6.5)	–	–
(b) Occasionally	10	10	5	2	9	36(39.1)	3	2	15	15	11	46(37.4)	–	–
(c) Never	6	9	10	10	9	44(47.8)	18	18	10	10	13	69(56.1)	–	6
8. Did the interns give you health related information through the following methods														
(a) Pamphlets	16	21	12	17	17	83(66.4)	9	7	21	24	16	77(61.6)	2	3
(b) Community participation	10	14	4	8	7	43(34.4)	7	5	–	–	12	24(19.2)	–	–
(c) Individual contact	21	19	17	20	18	95(76.2)	25	19	24	25	22	115(92.0)	3	2
9. Do you feel that activities of interns and health clubs were useful?														
(a) Yes	19	19	18	22	23	101(80.8)	16	13	15	13	19	76(60.8)	4(28.6)	3(50.0)
(b) No	6	6	7	3	2	24(19.2)	9	12	10	12	6	49(39.2)	10(71.4)	3(50.0)
10. Are the interns and health clubs still active?														
(a) Yes	–	–	–	–	–	–	–	–	–	–	–	–	–	–
(b) No	25	25	25	25	25	125	25	25	25	25	25	125	14	6

The interns were quite active in Barabanki as is evident from the response received by the control group who were covered by us. Around 55 per cent from the rural and nearly half from the urban areas have reported that they used to visit them once every week. However, in both areas around 39 per cent have informed that they visited the households once every month. In Gorakhpur, on the other hand, visits by interns were rarely made.

The KGMU had also formed Health Clubs in each area where the intervention work was in progress. However, while almost the entire control group from he urban area of Barabanki were aware of these health clubs, in the rural areas this awareness was only among three-fourths of the respondents. In the case of Gorakhpur none of the control group members contacted by us knew about the formation of these health clubs in the rural areas. In the urban area only about one-third of the total sample were in the know of the clubs. According to the responses received by us around one-fourth of the respondents from both rural and urban were not aware of the activities of these health clubs in Barabanki. Those from whom we received positive responses informed that the two main functions of these health clubs was that it was the meeting place for these interns to discuss among themselves the problems they were facing in the conduct of their duties and to find out effective means of promoting awareness about health among the control group. According to the respondents health club meetings were held occasionally – around 47 per cent response in both rural and urban areas. Although, the control group had no direct link with these health clubs around one-third used to visit them occasionally when they wanted some assistance from the intern. However, a majority of them never visited the health club.

As already indicated only a few people from the urban locality of Gorakhpur knew of the health clubs and all of them also know about its functions and they have informed that meetings of the club were held once a month. However, none of them even visited these health clubs.

The interns were supposed to spread health related information through the display of posters and other IEC material, through individual contact and community participation. As far as the first aspect of their activity is concerned the KGMU provided a single page giving in very brief information about the intervention work which the KGMU intends to do in the area, that it had selected interns for this purpose and formed health clubs. It also highlighted some points which had relevance to daily living. The other points did not have any direct relevance as such to daily living, health care or health protection. Besides this they also gave a small pamphlet which had pictorial scenes demonstration some daily exercises which would help the beneficiaries to remain fit. Over 60 per cent respondents accepted that these two pamphlets were shown to them by the interns in both rural and urban areas of Barabanki. They also

accepted that individual contact was made by the interns through visit to their households. These responses were quite high – touching around 76 per cent and 92 per cent in rural and urban areas of the district respectively. In Gorakhpur, although the interns met them rarely, whatever little information related was passed on by interns was through the pamphlets and some discussions which they held during the time of their personal visit to the households.

As far as the rural households are concerned around 81 per cent feel that the health clubs were useful. But the corresponding percentage in the case of urban areas was relatively low since only around 61 per cent respondents expressed this opinion. As many as 71 per cent of our respondents from the rural area of Gorakhpur did not feel that the health clubs have any useful role to play. In the urban area the opinion was equally divided among those who spoke well of the health clubs and those who thought otherwise. Our entire sample from both the districts confirmed the fact that both the interns and health clubs became disfunctional as soon as the KGMU project was over.

II.4 VIEWS OF RESPONDENTS ABOUT THE POSITIVE IMPACT OF INTERVENTION

The only way to assess the success of any scheme is to try and find out the extent to which it has succeeded in having a positive impact on the individuals towards whom it was targetted. We, therefore, had a separate section in the schedule for the control group where we asked them whether the intervention had any positive impact on them in different areas of daily living, health care and health promotion. This is shown in Table 2.4. The first thing which I brought out very clearly by the table is the fact that the degree of impact is much more in the urban areas as compared to the rural areas in Barabanki. This is quite understandable since our sample from the urban areas was relatively better educated. Moreover their urban background had given them greater access to knowledge about daily living and health care and also relatively better access to medical facilities. With these factors in mind it is easy to conceive that the interns really should not have had much of a difficulty at all trying to convey the ideas of daily living, health care and health promotion among the households which they were asked to look after. The extent to which positive impact could be felt varied between one aspect to another within the three broad areas – daily living, health care and health promotion as well as among the different rural and urban areas.

Out of those who did not feel the impact have responded that this was because of reasons such as lower levels of literacy, their faith in tradition and superstition, economic problems and their overall lack of interest in these aspects. This is the aspect which needs to be looked into seriously. No programmes, however good, can be successful without proper participation of the target group. And if there are people who show lack of interest then it calls for greater motivation and more efforts towards creating awareness among the individuals.

Table 2.4: **Respondents reporting Positive Impact of the Intervention (Control Group)**

Details	Barabanki												Gorakhpur	
	Rural						Urban						Rural	Urban
	1	2	3	4	5	Total	1	2	3	4	5	Total	1	1
1. Impact on daily living:														
(a) Smokeless kitchen	16	12	10	11	9	58	16	18	20	18	17	89	7	10
(b) Cleanliness while cooking	14	10	12	12	13	61	20	19	22	19	21	101	11	9
(c) Proper ventilation	17	15	10	8	12	62	15	16	17	14	18	80	7	5
(d) Cleanliness inside and around the house	19	10	15	13	20	77	17	18	19	17	20	91	10	7
(e) Balanced diet	7	9	10	7	14	47	19	20	19	18	16	92	9	8
(f) Regular exercises	10	8	7	7	11	43	19	11	18	12	14	74	5	4
(g) Proper daily routine	18	17	17	19	16	87	20	18	22	19	17	96	3	4
(h) Safe drinking water	22	21	17	20	20	100	19	18	15	18	22	92	11	6
(i) Harmonious atmosphere of the household	11	16	8	16	12	63	23	20	18	20	15	96	8	6
(j) Care of the elderly	23	22	20	22	18	105	21	17	20	22	24	104	10	8
2. Impact on Health Care														
(a) Knowledge of seasonal diseases	12	15	12	10	14	63	20	21	19	17	17	94	5	5
(b) Treatment only from qualified doctors	18	9	10	12	11	60	17	22	17	18	23	97	6	7
(c) Timely treatment of every ailment	20	9	14	16	10	69	21	24	19	20	19	103	4	8
(d) Discard all superstitions	16	11	12	10	7	56	18	19	16	15	18	86	6	5
(e) Knowledge about AIDS	10	5	8	5	11	39	11	18	13	10	14	66	3	7
(f) Knowledge related to Family Planning	18	20	14	11	7	70	18	22	17	19	14	90	5	8
(g) Evils of addiction	15	10	16	12	5	58	17	20	15	18	17	87	8	5
(h) How to avoid tension	9	7	6	7	6	35	19	23	18	17	15	92	2	6
3. Impact on Health Promotion														
(a) On health education	16	10	8	9	10	53	20	21	19	18	18	96	2	6
(b) On balanced diet	9	8	12	12	9	50	19	18	17	18	20	92	5	8
(c) On regular life	10	13	14	6	15	50	17	23	20	21	18	99	6	7
(d) On advantages of clean environment	18	15	17	14	14	78	19	20	18	19	21	97	2	8
4. Reason of no impact:														
(a) Illiteracy/Less education	4	5	.6	5	3	23	3	2	2	2	2	11	1	–
(b) Traditional method	11	9	7	10	13	50	9	8	5	9	10	41	8	8
(c) No interest	10	12	13	11	9	55	10	10	7	8	9	44	6	2
(d) Economic problem	7	11	9	8	6	41	6	5	8	4	5	28	7	6
5. As a result of the intervention do you feel that there has been a positive impact in your family?														
(a) Yes	8	5	7	4	6	30(24.0)	11	7	8	10	9	52(41.6)	2	3
(b) No	8	8	10	6	7	39(31.2)	7	13	3	–	7	30(24.0)	12	4
(c) To some extent	9	12	8	15	12	56(44.8)	7	5	14	8	9	43(34.4)	7	9
6. Suggestions for improving intervention programme														
(a) Proper publicity about health care through posters/exhibitions	9	10	7	8	9	43	10	8	7	5	6	36	6	3
(b) Intervention on a regular basis	13	8	11	12	10	54	8	9	12	6	11	46	9	11
(c) Proper training and remuneration to Interns	7	11	10	7	8	43	6	5	6	10	7	34	10	4
(d) PHC Doctor should also be involved	8	9	7	5	7	36	7	10	5	9	7	38	6	9
(e) No response	2	3	3	4	2	14	3	2	2	3	2	12	3	–

The effects of the lack of interest is best reflected from the fact that despite many people suggesting that the intervention had a positive impact on their attitude towards these aspects, when we look at actual acceptability of these habits of daily living and health care less than one-fourth of the respondents from rural and barely around 42 per cent from the urban

areas have accepted that their households have started following the guidance which was given to them by the KGMU doctors during their visits or by the interns who were to continue the work even in the absence of the KGMU team. Around 45 per cent from rural and around one-third from the urban areas say that they are following the advice given to them to some extent.

The suggestions offered by the respondents for bringing about improvement in the intervention programme are that there should be proper publicity about healthcare etc. through extensive use of posters and other IEC material and by holding regular exhibitions and camps. That intervention should be taken up regularly so that people keep being reminded about advantages of daily living and health care. They feel that the interns after being selected, should be given proper training. Only then can they do their work effectively. Moreover, they should also be given some remuneration which will serve as an incentive to put in hard work. Finally, they felt that if the work is to achieve success the doctor attached to the PHC must be involved extensively in the entire process from the stage of initiation till its completion.

II.5 PERCEPTION OF THE CONTROL GROUP MEMBERS

One of the main areas of focus in health care was to impress upon on the control group the fact that in case of an illness they should only visit a qualified doctor. Our findings reveal that if we look at the pre and post-intervention scenario, in the rural areas only around 68 per cent of our respondents were going to a recognized doctor for treatment of various ailments this total included those going to the government hospital (around 37 per cent) and those visiting private doctors (around 31 per cent), before the KGMU started its behaviour intervention. After the intervention this percentage has gone up to nearly 89 per cent with an almost equal share out of this going to public and private agencies respectively for treatment. Those not going to a recognized doctor relied on household treatment, local hakeem, or the 'jhola' type doctor. In the urban areas around 95 per cent respondents had been going to regular doctor even before intervention. This comprised of around 43 per cent visiting government hospitals and 52 per cent getting treated in private hospitals/clinics. Intervention has ensured that even the remaining 5 per cent are now going to a recognized doctor (Table 2.5).

It can be observed that there is a greater reliance on private hospitals/clinics. In the case of rural areas before intervention around 31 per cent respondents had been visiting them. But after intervention their proportion has gone up to around 46 per cent. These percentages are even higher in the urban areas. Before intervention 52 per cent respondents had been going for treatment to private agencies and this share went up marginally to 56 per cent.

Table 2.5: **Perception of the Respondents (Control Group)**

Details	Barabanki																						Gorakhpur			
	Rural												Urban										Rural		Urban	
	1		2		3		4		5		Total		1		2		3		4		5		Total		1		1	
	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A
1. **Where do you go for treatment**																												
Government Hospital	10	12	10	14	6	9	2	6	18	13	46	54	9	8	11	10	9	10	9	10	16	17	54	55	7	10	2	4
Private Hospital/Clinics	10	13	7	10	6	9	13	17	3	8	39	57	14	17	12	15	15	15	16	15	8	8	65	70	6	8	11	11
Household Treatment	1	--	1	--	3	2	2	1	--	--	7	3	--	--	--	--	--	--	--	--	--	--	--	--	2	--	2	--
Hakeem	1	--	2	1	5	3	2	--	2	1	12	5	--	--	--	--	--	--	--	--	--	--	--	--	6	1	--	--
Local Quack	3	--	5	--	3	2	3	1	2	1	16	4	2	--	2	--	1	--	--	--	1	--	6	--	--	2	1	1
Ojha	--	--	--	--	2	--	3	--	--	2	5	2	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--
2. Are the existing facilities of Govt. hospitals satisfactory?																												
Yes	11		14		15		6		16		62		20		17		13		10		18		78		10		10	
No	14		11		10		19		9		63		5		8		12		15		7		47		11		6	
3. If No, Lack of facilities:																												
Medicine not provided	8		3		2		7		4		24		2		6		10		10		7		35		9		2	
No proper care	6		5		7		12		5		35		4		5		2		9		2		22		7		4	
Doctors not regular	7		5		4		10		3		29		--		--		--		--		--		--		3		--	
4. **Do you find a difference between the Interns and ANM/Health worker**																												
Yes	18		12		18		15		9		72(57.6)		17		11		16		12		12		68(54.4)		--		--	
No	7		13		7		10		16		53(42.4)		8		14		9		13		13		57(45.6)		21		16	
5. **If Yes, who are better**																												
Interns	10		5		15		11		4		45(62.5)		10		5		10		11		3		39(57.4)		--		--	
ANM/Health Worker	9		6		3		4		5		27(77.5)		5		4		7		4		9		29(42.6)		--		--	
6. **How were Interns better**																												
They used to visit the household more frequently	10		5		15		11		4		45		8		5		7		11		3		34		--		--	
They provided good advise	4		3		5		5		3		20		10		4		9		3		1		27		--		--	
They helped in getting treatment	2		--		2		3		1		8		2		2		4		6		--		14		--		--	
7. **How are ANM/Health Worker Better**																												
They are properly trained	8		6		3		4		5		26		2		3		6		3		9		23		--		--	
They can provide better guidance	2		2		2		2		2		10		3		2		5		4		1		15		--		--	
8. Do you feel that such intervention should be carried out regularly																												
Yes	25		25		25		25		25		125		15		7		20		22		16		80(64.0)		14(66.7)		16	
No	--		--		--		--		--		--		10		18		5		3		9		45(36.0)		7(33.3)		--	

N.B: The words B and A in the column mean Before Intervention (B), and After Intervention (A)

In the case of Gorakhpur as well as the proportion of those visiting a qualified doctor has gone up from around 62 to 86 per cent when we look at the pre and post-intervention scenario. In the urban area this percentage was around 81 per cent before intervention and went upto 88 per cent as a result of the intervention.

In both districts it is observed that a high proportion of the respondents even in rural areas are going in for private treatment. This is happening even when the treatment in the government hospitals is very highly subsidised. One of the factors which go against the popularity of government centres is that they do not offer proper facilities. Doctors do not come regularly, do not take proper care of patients and even medicines which were to be provided free are not easily available to the people who visit them. Consequently, half the respondents in rural areas have expressed their dissatisfaction with the facilities available in government hospitals. Even in the urban areas around 38 per cent of the control group members are not satisfied with the government hospitals. Even in the case of Gorakhpur around half the respondents of rural areas and 38 per cent from urban areas were critical of the government run hospitals (Table 2.5).

We asked the control group members whether they felt any difference between the community interns selected by the KGMU team and the government appointed ANM/Health workers. A total of 58 per cent responses in rural areas of Barabanki were that a difference does exist. Even in the urban area the response accepting a marked difference between the two was found as reported by around 54 per cent respondents. Out of those who felt that there was a difference, a relatively higher proportion felt that the interns were better than ANM/ health workers. This proportion was 62.5 and 57.4 per cent in rural and urban areas respectively. The grounds on which they felt that interns were better and that they used to visit their household relatively more frequently and give a health related advice and also assisted them when any one fell ill. As against this, those who feel that the ANM/health workers are better do so because of the fact that they are more qualified and as a result of this training they can offer better guidance on matters related to health. In the rural areas all the respondents were of the opinion that such interventions should be done on a regular basis. In the urban areas however, those sharing this view were only around two-thirds of the total respondents. In Gorakhpur the scenario was reversed. While all from urban areas favoured the idea of having intervention on a regular basis, only around two-thirds from the rural areas thought so.

To sum up therefore, the control group consisted of a majority of persons who were literate. The proportion of educationally qualified persons was higher in the urban areas. The

average household income was around Rs.61 thousand in rural and around Rs.97 thousand in the urban areas of Barabanki. In the case of Gorakhpur the average income was around Rs.73 thousand and Rs.78 thousand in rural and urban areas respectively. The KGMU team did work in areas of daily living, health care and health promotion. Around 4-6 members from KGMU visited both the districts and made on an average five visits in the rural and urban areas in Barabanki and around 3-4 visits in Gorakhpur. The respondents have confirmed that interns were appointed by the KGMU to assist in the work of behaviour intervention. While in Barabanki the interns were quite active they were not so in Gorakhpur. However, the interns discontinued all their activities as soon as the intervention work was over.

The respondents claim that the intervention work did have a positive impact on them. However, the actual position is that these effects were shortlived and lasted only while the KGMU work was in progress. This is reflected by the fact that even according to the respondents themselves only around one-fourth in rural and around 41 per cent in urban areas have actually adopted all the various suggestions given by KGMU. However, the main plus point of the intervention is that people are now going to regular doctors in much larger numbers after intervention in rural areas as compared to what they did prior to the intervention. Many of the respondents feel that the interns are better as compared to the ANM/health workers appointed by KGMU.

CHAPTER III

HEALTH AWARENESS AMONG UNCONTROLLED GROUP

One of the ways to assess the impact of any intervention programme is to simultaneous select a sample from the uncontrolled group along with that from the control group and assess the variations in the awareness levels among the members of the two groups. One would obviously expect a relatively higher degree of awareness among the control group since they have been the direct beneficiaries of the interventions. We, therefore, selected a sample of 10 households from each of the five rural and urban areas of Barabanki and the single village and urban mohalla of Gorakhpur to try and assess the differences between them and the control group members with respect to daily living, health care and health promotion. In this chapter we will discuss their general characteristics, knowledge of aspects related to daily living, health care and health promotion, awareness among the households about the KGMU intervention, if any, their general preference with respect to treatment of ailments and their views about the existing medical facilities being provided by the government in their area.

3.1 GENERAL INFORMATION ABOUT THE UNCONTROLLED GROUP

We obtained details about this group related to their age, education, caste and household income, etc. An effort was made to select the households in such a way that it would represent the low, medium and high income categories. All this information has been tabulated and is presented in Table 3.1. In the rural areas of Barabanki district approximately 40 per cent respondents were found in the two age groups of 24-45 and 45-60 years. The rest were above 60 years. In the urban areas around 54 per cent were concentrated in the age group 45-60 years and were followed by those in the age group 25-45 years (36 per cent). In rural Gorakhpur they were almost evenly distributed in three age groups as is evident from the table while in the urban area half the total respondents were in the age group 25-45 years. Looking at the households from a caste-wise basis the OBC category was dominant in rural Barabanki accounting for half our respondents. In urban Barabanki the maximum number (42 per cent) were from the minority group. There were variations among the different villages. Harakh for example had only OBC households while in the case of Mohana only one household belonged to the OBC category. Similarly, in the case of urban areas Durgapuri had no minority household while Balmiki Nagar had only one minority household. In Gorakhpur the OBC category dominated in the village while in the urban area maximum number of households were from general caste.

Table 3.1: **General Information about Background of the Uncontrolled Group**

Characteristics	Barabanki												Gorakhpur	
	Rural						Urban						Rural	Urban
	1	2	3	4	5	Total	1	2	3	4	5	Total	1	1
Age group:														
Below 25 years	--	--	--	--	--	--	--	--	--	--	1	1	3	1
25 — 45 years	5	3	3	4	5	20	1	2	1	8	6	18	3	5
45 — 60 years	3	3	4	6	3	19	7	8	7	2	3	27	3	3
Above 60 years	2	4	3	--	2	11	2	--	2	--	--	4	1	1
Caste:														
General	--	--	1	2	4	7	4	1	4	--	--	9	1	6
SC/ST	10	6	5	3	1	25	1	3	6	2	1	13	6	2
OBC	--	4	4	4	5	17	4	3	--	--	--	7	3	--
Minority	--	--	--	1	--	1	1	3	--	8	9	21	--	2
Educational Qualification:														
Illiterate	--	4	3	2	3	12	1	--	2	4	3	10	--	--
Upto Class VIII	6	4	7	5	4	26	4	2	1	2	4	13	5	3
High School/Intermediate	3	2	--	3	3	11	3	5	1	1	2	12	3	2
Graduate and above	1	--	--	--	--	1	2	3	6	3	1	15	2	5
Average size of Households	7.5	5.2	7.3	7.9	6.1	6.8	4.7	5.5	6.1	5.1	5.4	5.4	7.4	5.3
Income Category:														
Low	3	3	3	4	3	16	1	--	3	4	5	13	1	1
Medium	3	5	6	3	5	22	6	6	3	3	2	20	9	8
High	4	2	1	3	2	12	3	4	4	3	3	17	--	1
Average income of respondent	45000	26600	32400	44300	57650	41190	54400	87700	70400	62600	65600	68144	36800	45500
Average income of the household	87200	41950	48800	68300	59550	61160	69060	90100	84600	75600	67400	77352	48300	51900

N.B.: In Barabanki, the names of villages and urban localities are as follows:

Rural – 1. Harakh; 2. Israuliseth; 3. Abahipur; 4. Ibrahimabad ; 5. Mohana.

Urban- 1. Balmikinagar; 2. Lakhpedebagh; 3. Durgapuri ; 4. Satya Premi Nagar ; 5. Peerbatawan

In Gorakhpur

Rural – 1. Araji Chauri

Urban- 1. Humayunpur

From the point of view of educational qualifications around one-fourth of our respondents from rural areas and around 20 per cent from the urban areas were illiterate. Those who had studied upto Class VIII accounted for 52 per cent of the respondents in rural areas. Consequently only around 25 per cent had educational qualification above Class VIII. In the case of the urban areas however 30 per cent respondents were graduates or above. Almost an equal number were of those who had studied upto Intermediate level or only upto Class VIII. In Gorakhpur, not a single respondent was illiterate from rural or urban area. However, while 50 per cent had studied only upto Class VIII in rural area, in the urban area half he respondents were graduates or above.

The average household size worked out to be 6.8 in rural Barabanki and 5.4 in the urban area of the district. In Gorakhpur the corresponding figures were 7.4 and 5.3 for the rural and urban area respectively. The average income of households worked out to be Rs.61 and

Rs.77 thousand among he rural and urban households respectively in Barabanki. These figures were much lower in the case of Gorakhpur where average household income was only around Rs.48 thousand in the rural area and Rs.52 thousand in urban area (Table 3.1).

3.2 AWARENESS AMONG THE UNCONTROLLED GROUP REGARDING HEALTH CARE

In a situation where literacy levels are as high as 75 and 80 per cent in the rural and urban areas respectively among the members selected from the uncontrolled group in Barabanki, it is not at all surprising to find that people have shown awareness in varying degree regarding different aspects of daily living. The awareness levels are relatively higher in the case of urban areas as compared to the rural areas and this too is understandable since the urban population has greater exposure about these aspects. Even in the case of health care a similar picture emerges with a sizeable number of the respondents having knowledge about aspects of health care. What is encouraging is to note that over 70 per cent respondents were aware of the fact that treatment of all ailments should be done without a delay and that one should visit only a qualified doctor for treatment. The respondents have indicated the various sources from where they have gained information related to daily living and health care. In the rural areas the two most important sources are family members and the media. In the urban areas the ranking is reversed and media is most important followed by the family members. It is unfortunate that the health workers do not seem to be playing an active role in spreading awareness and only a few respondents have named them as their source of information (See Table 3.2). However, there is considerable difference between having awareness about these aspects of daily living and actually making practical use of this knowledge in their daily routine. Looking at the responses received it is revealed that less than half the respondents in rural areas are actually following the best suited methods of daily living and health care. Fortunately, in the urban areas the proportion of such persons is around 70 per cent. Those who do not follow these simple rules related to daily living and health care claim that this is so since they do not have time or sufficient finances to ensure that their houses are properly ventilated, to take a proper balanced diet and only visit a qualified doctor etc. for getting treatment. At least these people have given a reason which sounds justified to a degree. But those in the rural areas who claim that they are not interested in proper health care are the ones who need to be motivated because this is a case of total ignorance (Table 3.2). In Gorakhpur also we find a similar pattern as far as awareness about daily living and health care is concerned. However, in both rural and urban areas 60 per cent of the respondents claim that they are also making practical use of this awareness in their daily routine.

Table 3.2: **Awareness among the Uncontrolled Groups about Daily Living and Health care**

Details	Barabanki												Gorakhpur	
	Rural						Urban						Rural	Urban
	1	2	3	4	5	Total	1	2	3	4	5	Total	1	2
1. **Daily living:**														
(a) Smokeless kitchen	6	5	4	6	4	25	7	8	9	6	5	35	4	4
(b) Cleanliness while cooking	8	7	7	6	8	36	7	9	9	8	10	43	7	5
(c) Cleanliness inside and around the house	7	6	6	7	7	33	9	10	8	8	9	44	6	6
(d) Personal hygiene	8	6	7	6	8	35	6	7	9	10	8	40	6	4
(e) Cross ventilation in the house	4	6	6	5	6	27	7	8	8	8	7	38	3	5
(f) Balanced diet	4	3	3	4	3	17	8	9	10	8	8	43	5	5
(g) Safe drinking water	8	8	6	7	7	36	8	8	9	9	8	42	8	7
2. **Knowledge of Health Care**														
(a) Treatment without delay	7	6	7	8	8	36	7	8	8	8	6	37	7	6
(b) Treatment only from qualified doctors	7	7	8	7	8	37	8	9	7	9	7	40	6	7
(c) AIDS awareness	4	5	4	3	5	21	5	7	4	4	5	25	3	3
(d) Knowledge related to Family Planning	6	6	5	4	6	27	7	8	8	8	5	36	8	6
(e) Significance of regular exercise	4	5	4	5	6	24	6	7	8	9	4	34	4	5
(f) Awareness that tension leads to mental illness	3	4	3	3	5	18	6	7	4	5	4	26	3	3
(g) Evils of drug addiction	5	6	6	7	7	31	7	9	7	9	6	38	7	5
3. **Source of information about daily living and health care**														
(a) Family members	4	3	4	3	4	18	2	1	2	3	4	12	5	3
(b) Health worker	–	1	1	2	2	6	1	5	1	1	1	9	1	1
(c) Media sources	4	2	3	2	2	13	2	4	5	3	2	16	4	3
(d) Neighbours	–	2	–	1	–	3	3	–	2	3	1	9	–	–
(e) KGMU team/Interns	2	1	1	1	1	6	1	–	–	–	1	2	–	–
(f) Aanganwadi workers	–	1	–	–	1	2	1	–	–	–	1	2	–	3
4. **Do you use this knowledge in your daily life**														
(a) Yes	4	5	4	5	6	24	7	8	6	8	6	35	6	6
(b) No	6	5	6	5	4	26	3	2	4	2	4	15	4	4
5. **If No, reasons?**														
(a) Lack of time	3	2	3	4	2	14	1	–	–	–	–	1	1	1
(b) Economic problem	2	3	3	2	2	12	2	1	1	1	2	7	2	2
(c) No interest	1	2	2	3	3	11	–	–	1	–	–	1	1	–
(d) Lack of knowledge	1	2	1	2	1	7	–	1	2	1	2	6	1	1

3.3 KNOWLEDGE ABOUT KGMU INTEVENTION AMONG THE UNCONTROLLED GROUP MEMBERS

Despite the fact that the uncontrolled group members in Barabanki did not come in direct contact with the members of the KGMU team, around 72 and 76 per cent of them from rural and urban areas respectively were aware of the fact that a team of doctors had come to their area and worked in the area of intervention. In the rural areas a larger proportion had knowledge related to the work done in the field of daily living and health care as compared to health promotion. However, almost an equal number were aware of all these three activities in the urban area of Barabanki. Strangely enough while 60 per cent were aware of the work done by the KGMU in rural area of Gorakhpur, only 50 per cent had this knowledge in the urban area (see Table 3.3 for details).

Table 3.3: **Knowledge about KGMU Intervention**

Details	Barabanki												Gorakhpur	
	Rural						Urban						Rural	Urban
	1	2	3	4	5	Total	1	2	3	4	5	Total	1	1
1. Do you have any knowledge about KGMU intervention:														
(a) Yes	4	8	10	6	8	36(72.0)	9	8	7	7	7	38(76.0)	6	5
(b) No	6	2	–	4	2	14(28.0)	1	2	2	3	3	12(24.0)	4	5
2. If Yes, which types of intervention were done?														
(a) Daily living	4	8	8	6	8	34(68.0)	9	8	7	7	6	35(70.0)	6	3
(b) Health Care	3	8	9	4	7	31(62.0)	9	7	7	6	7	36(72.0)	6	3
(c) Health Promotion	3	6	5	3	6	23(46.0)	8	7	7	6	6	34(68.0)	3	2
3. In your opinion intervention was useful?														
(a) Yes	3	6	8	4	6	27(75.0)	7	5	6	5	4	27(71.1)	4	3
(b) No	1	2	2	2	2	9(25.0)	2	3	1	2	3	11(28.9)	2	2
4. If intervention was Useful, are you also benefitted by it?														
(a) Yes	3	4	7	4	3	21(77.8)	4	4	4	3	2	17(63.0)	4	2
(b) No	–	2	1	–	3	6(22.2)	3	1	2	2	2	10(37.0)	2	1
5. Do you have any knowledge about Interns/ Health Clubs?														
(a) Yes	4	7	6	4	5	26(72.2)	5	4	4	3	3	19(50.0)	4	3
(b) No	–	1	4	2	3	10(27.8)	4	4	3	4	4	19(50.0)	2	2
6. If Yes, what is your view about them?														
(a) Very Good	–	1	–	–	1	2	–	1	–	1	–	2	–	–
(b) Good	1	2	1	1	2	7	1	1	2	1	2	7	2	–
(c) Average	2	4	3	3	2	14	3	2	2	1	1	9	2	1
(d) Not so good	1	1	1	–	–	3	1	–	–	–	–	1	–	2

Among those who were aware of the intervention around three-fourths from rural areas and over 70 per cent from urban areas in Barabanki were of the opinion that this intervention was useful. In Gorakhpur the proportion of people expressing satisfaction with intervention was relatively lower. Out of the total number of respondents who were aware of the intervention around 72 per cent from rural and 50 per cent from urban areas of Barabanki were aware of the fact that the KGMU had selected interns and had formed health clubs. In Gorakhpur the percentage was 66 and 50 respectively in the rural and urban areas. However, a relatively higher proportion of these respondents felt that these interns or clubs were average or not good. This holds for both rural and urban areas of both districts (Table 3.3).

3.4 RESPONDENTS PERCEPTION REGARDING EXISTING HEALTH FACILITIES

We enquired from the respondents about their general pattern of getting treatment for any ailment. In the case of the rural areas of Barabanki it was found that while only around 36 per cent went to the government run PHC/CHC or sub-centre for treatment, around 40 per cent preferred to go to a private doctor. This could be so because the PHC and CHC etc. are not giving them satisfactory services. In fact this has been verified by the statements of the respondents themselves since 58 per cent have expressed their dissatisfaction with the facilities

which are available to them in the government hospitals. In the urban area as such it is found that 54 per cent of the respondents prefer a government hospital while 40 per cent are in favour of going to treatment to a private hospital. This is so despite the fact that only 48 per cent are satisfied with the services which are provided to them in the government hospitals. In Gorakhpur the scenario is slightly different and 60 per cent respondents of rural areas get treated in government hospitals while in the urban area 80 per cent are relying on private hospitals for their medical treatment. However, whether people are going to a government or private source for treatment it is a very good sign to see that majority of the people are going to a proper agency which has qualified doctors for their treatment. The reasons for their dissatisfaction with government hospitals are on account of the fact that government hospitals do not have regular supply of medicines, treatment is not proper since doctors do not come regularly, etc. These are the common grievances of the people in both districts and in rural as well as urban areas (see Table 3.4 for details).

Table 3.4: **Views of Respondents Regarding Health Facilities**

Details	Barabanki												Gorakhpur	
	Rural						Urban						Rural	Urban
	1	2	3	4	5	Total	1	2	3	4	5	Total	1	1
1. Where do you normally go for treatment?														
(a) Government hospital	5	3	3	2	5	18(36.0)	5	6	6	3	7	27(54.0)	6(60.0)	2(20.0)
(b) Private hospital	5	4	3	5	3	20(40.0)	4	4	4	6	2	20(40.0)	3(30.0)	8(80.0)
(c) Hakeem	–	2	2	2	–	6(12.0)	–	–	–	–	1	1(2.0)	–	–
(d) Household Treatment	–	–	–	–	–	–	–	–	–	–	–	–	1(10.0)	–
(e) Quacks	–	1	2	1	2	6(12.0)	1	–	–	1	–	2(4.0)	–	–
(f) Ojha	–	–	–	–	–	–	–	–	–	–	–	–	–	–
2. Are the existing facilities of government hospital satisfactory?														
(a) Yes	5	4	4	2	6	21(42.0)	5	4	6	3	6	24(48.0)	6(60.0)	5(50.0)
(b) No	5	6	6	8	4	29(58.0)	5	6	4	7	4	26(52.0)	4(40.0)	5(50.0)
3. If No, lack of facilities														
(a) Lack of medicines	3	4	4	6	3	20	2	3	–	3	1	9	4	1
(b) No proper care/treatment	3	2	3	5	3	16	–	1	2	2	2	7	2	2
(c) Doctors irregular	4	3	1	2	1	11	2	2	2	1	1	8	3	1
(d) Inadequate facility of pathological test	1	–	–	1	1	3	–	1	–	3	2	6	–	2
(e) Shortage of dedicated doctors	2	–	1	1	2	6	1	1	–	–	–	2	–	1

To sum up, therefore, it is found that a majority of our respondents are literate. Illiterates accounted for less than twenty per cent of urban respondents and around 25 per cent in rural areas. The average size of the household was 6.8 in rural and 5.4 in urban areas of Barabanki. The corresponding figures were 7.4 and 5.3 in the case of Gorakhpur. Average income of households worked out to Rs.61 thousand in rural areas of Barabanki and Rs.77 thousand in urban areas. In he case of Gorakhpur the income was found to be Rs.48 and Rs.52 thousand in rural and urban areas respectively.

In a situation where literacy levels are quite high it was not surprising to find that people have shown awareness regarding various aspect of daily living and health care in both the districts. However, when it comes to utilizing this knowledge in their day-to-day behaviour less than half the respondents from rural areas and around 70 per cent in urban areas are actually following the advise given regarding daily living and health care.

Despite the fact that this group did not have any direct link with the control group, a large number of them know about the KGMU intervention, health interns, etc. However, a relatively lower proportion felt that the interns were effective.

The encouraging fact which emerges is that a very high percentage of respondents are going to qualified doctors whether in the government or private hospitals for their treatment. But by and large they are dissatisfied with the facilities offered by the government run hospitals.

CHAPTER IV

BACKGROUND OF INTERNS AND THEIR PERCEPION OF THE KGMU INTERVENTION

In the two chapters preceding this one we have carried out an analysis of the control group members with respect to their background, the impact which has been made on them as a result of the intervention carried out by the team from KGMU and their views related to the intervention as well as about the medical facilities which are available to them in government hospitals and whether or not they are satisfied with these facilities. A similar analysis was also carried out of the members who were from the uncontrolled group to find out their background, whether they were aware of the work done in the area of daily living, health care and health promotion and what they thought of the work which the KGMU had attempted. We also tried to find out what is the normal approach adopted by them in case they want to get treatment for any ailment.

In this chapter we will focus our attention on the interns who were selected by the team of KGMU and about the health clubs which were also formed by the KGMU team. Besides this we will also highlight the main points which have arisen from our focussed group discussions with a few Pradhans, Sabhasads, staff of the PHC, etc. related to the effectiveness and utility of the intervention work.

4.1 THE COMMUNITY INTERNS

In the entire work of carrying out behaviour intervention the community interns were to play a pivotal role. In fact, it would be fair to state that the success of the intervention programme primarily revolved around the sincerity, zeal, regularity and dedication put in by the interns in spreading awareness among the control group members about the necessity to bring about changes in their attitude towards daily living, health care and health promotion. The KGMU team visited all the villages and urban localities from time to time and did speak to members from the control group. But it was the interns who had a special role since they were selected from the same areas from which the control group members had been chosen and therefore it was expected that being from the same area the interns would be able to communicate with people more effectively and will be able to influence them to adopt the methods which would enable them to enjoy a better health.

On an average the KGMU appointed 4-5 interns in each village and urban locality. Since they were to create awareness among the people the effort was to select educated people for this purpose. The background of the interns is being provided in Table 4.1. It is very clear from Table 4.1 that out of the five villages in Barabanki 5 interns were selected in three and 4 interns in the other two villages. A similar pattern was found in the urban areas except for the fact that in one locality there were only three interns. In Gorakhpur, however, 4 interns were selected for the rural area and one in the case of the urban area.

Since the interns were expected to spread awareness among people it was essential that they should be educated enough and have communication skill to be able to convey the message which they wanted to spread effectively. We, therefore, find that in the 5 villages of Barabanki combined almost 61 per cent of the interns were educated upto the high school or intermediate level. While in the urban localities the overall number of interns with education upto graduate or above accounted for nearly 73 per cent of total interns. Even in Gorakhpur the interns were highly educated. Three-fourths in the rural areas and all in the urban locality were graduates.

There were mainly three methods adopted by the KGMU team for selection of these interns. The first was a random house to house survey and direct contact with members of he households. From among them they selected suitable candidates for the interns job. The second was by holding a meeting of the village community or in the urban locality and then identifying educated and willing persons for assisting the KGMU in the intervention work by working as interns. In the villages of Barabanki these were the two most important methods adopted. However, the single most important method in the urban areas of Barabanki was identification during meetings. The third method, though less popular, was by asking an already selected intern to suggest names of other people who are educated and would be willing to take up the assignment. In Gorakhpur all the four interns in the village were selected directly by the KGMU team while in the urban areas one was selected by KGMU and the name of the second had been proposed by the first intern.

Since the interns were to play an important role in the intervention work they should have been provided proper training. However, over half the interns have reported that they were not given any training (56.5 per cent). Even in the urban areas only half the interns were given training. In the case of Gorakhpur neither the interns selected from rural or urban areas were given any training. In fact even the interns who were given some training, the training was not formal during which the interns were given detailed instructions as to how they were expected to influence the control group.

Looking at the age group-wise distribution of the interns a majority of them were concentrated in the age group of 25-45 years in the rural and urban areas of both Barabanki and Gorakhpur. Even among individual villages and urban localities the pattern was the same (Table 4.1).

Table 4.1: **Background of Interns and their selection procedure**

Details	Barabanki												Gorakhpur		
	Rural						Urban						Rural	Urban	Total
	1	2	3	4	5	Total	1	2	3	4	5	Total	1	2	
1. **Age Groups:**															
(a) Below 25 years	2	1	–	–	–	3(13.0)	1	3	–	2	–	6(27.3)	2(50.0)	–	2(33.3)
(b) 25 — 45 years	3	3	3	3	5	17(73.9)	3	2	4	3	3	15(68.2)	2(50.0)	2(100.0)	4(66.7)
(c) 45 — 60 years	–	1	1	–	–	2(8.7)	1	–	–	–	–	1(4.5)	–	–	–
(d) Above 60 years	–	–	–	1	–	1(4.4)	–	–	–	–	–	–	–	–	–
Total No. of Interns	5	5	4	4	5	23(100.0)	5	5	4	5	3	22(100.0)	4(100.0)	2(100.0)	6(100.0)
2. **Educational Qualification:**															
(a) Upto Class VIII	–	–	2	2	–	4(17.4)	–	–	–	–	–	–	–	–	–
(b) High School/Intermediate	3	3	2	2	4	14(60.9)	2	–	1	2	1	6(27.3)	1(25.0)	–	1
(c) Graduate and above	2	2	–	–	1	5(2.7)	3	5	3	3	2	16(72.7)	3(75.0)	2(100.0)	5
3. **How was selection done:**															
(a) Directly by KGMU team	2	2	1	1	4	10(43.5)	1	1	1	–	2	5(22.7)	4	1	5
(b) Through meeting	3	2	2	3	1	11(47.8)	4	–	3	5	–	12(54.6)	–	–	–
(c) On the recommendation of Intern	–	1	1	–	–	2(8.7)	–	4	–	–	1	5(22.7)	-	1	1
4. **Was training provided:**															
(a) Yes	3	–	3	4	–	10(43.5)	–	3	4	4	–	11(50.0)	–	–	–
(b) No	2	5	1	–	5	13(56.5)	5	2	–	1	3	11(50.0)	4	2	6
5. Average number of households per intern	25	21	40	25	28	27	20	20	26	25	27	23	–	43	–
6. **Functions of the Health Club:**															
(a) To discuss progress of the work of interns	5	5	4	3	5	22	4	3	4	5	3	19	NR	2	–
(b) To solve problems of interns	3	–	–	2	2	7	5	5	4	5	–	19	NR	–	–
7. Duties assigned to you:															
(a) Daily living	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√
(b) Health Care	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√
(c) Health promotion	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√
8. Frequency of your visit in control group HH															
(a) Twice in a month	2	–	–	–	–	2(8.7)	3	5	3	–	2	13(59.1)	Nil	Nil	Nil
(b) 4-5 times in a month	3	5	4	4	5	21(91.3)	2	–	1	5	1	9(40.9)	Nil	Nil	Nil
9. No. of visits done by KGMU team in health club and control HH residence:															
(a) 2-3 times	–	–	1	–	–	1(4.4)	1	5	3	2	3	14(63.6)	4	–	4
(b) 4-5 times	1	–	1	3	–	5(21.7)	3	–	1	2	–	6(27.3)	–	1	1
(c) 6-7 times	3	–	1	1	–	5(21.7)	1	–	–	1	–	2(9.1)	–	1	1
(d) 8 and above	1	5	1	–	5	12(52.2)	–	–	–	–	–	–	–	–	–
10. Number of KGMU Team Members:															
(a) Upto 5	–	–	–	–	1	1(4.4)	–	–	–	1	–	1(4.5)	–	1	1
(b) 6-10	2	–	2	–	1	5(21.7)	2	–	1	4	3	10(45.5)	4	–	4
(c) 11-15	3	5	2	4	3	17(73.9)	3	5	3	–	–	11(50.0)	–	1	1

In the case of Barabanki the KGMU team had selected a total of 100 households as the control group from each village and urban locality. Consequently, each interns were allotted around 20-25 households for carrying out their intervention work. In some cases the number exceeded 25 and so the average number of households per intern worked out to be 27 in the five villages taken together and 23 in the five urban localities taken together in Barabanki district. The duties which were assigned to these interns was to create awareness among the members of the control group with respect to various aspects related to daily living, health care and health promotion.

The interns from the five villages of Barabanki have reported that they generally visited the families allotted to them 4-5 times a month (91.3 per cent response). The interns of the urban localities were generally visiting the households allotted to them generally twice a month as indicated by around 59 per cent interns.

The KGMU had also set up health clubs in each locality, whether rural or urban. The interns were the members of these health clubs and the main function of these health clubs was that they served as meeting places where the interns could discuss among themselves the problems which they were facing in trying to convince people to follow their instructions related to daily living, health care and health promotion. These health clubs were located generally in the residence of any intern from among the 4-5 interns of a given rural or urban area (Table 4.1).

As reported by the interns the frequency of the visits of the KGMU team to the households of the control group and the health clubs was high as far as the rural areas of Barabanki is concerned. As many as 52 per cent interns have told that the KGMU team visited their area more than 8 times. However, the response from the urban localities indicate that KGMU members visited their locality only 2-3 times during the entire period when the intervention work was in progress.

It has already been indicated in Chapter II that the KGMU team was supposed to comprise of a total of six members. However, according to the interns particularly from the rural areas of Barabanki, the total number of individuals visiting the villages was much more. In fact, in the rural areas of Barabanki, the recorded information is that the team visiting from KGMU comprised of 11 to 15 members as reported by almost 74 per cent interns. Even in the urban areas half of them have reported that the KGMU team comprised of 10-15 members while another 45 per cent reported that the team constituted of 6-10 members. In the case of the village in Gorakhpur the information provided by interns is that the team had 6-10 members. There was variation in the information provided by the two interns from the urban locality of Gorakhpur. While one reported that the team had around five members, according to the second intern the KGMU team had 11-15 members.

4.2 PERCEPTION OF THE INTERNS WITH RESPECT TO THE INTERVENTION WORK

We had asked the control group members to offer their views about the intervention work carried out by the KGMU in order to assess its efficacy from their point of view. In a similar fashion we also enquired from the interns about the work done by the KGMU in terms of its utility and impact. The responses received in this connection have been tabulated and are presented in Table 4.2.

Table 4.2: **Perception of Interns Related to the Intervention Programme**

Details	Barabanki												Gorakhpur		
	Rural						Urban						Rural	Urban	Total
	1	2	3	4	5	Total	1	2	3	4	5	Total	1	2	
1. How was the KGMU Team?															
(a) Very good	1	–	1	2	1	5(21.7)	4	–	–	2	1	7(31.8)	4	2	6
(b) Good	3	4	3	2	4	16(69.6)	1	5	4	3	1	14(63.6)	–	–	–
(c) Average	1	1	–	–	–	2(8.7)	–	–	–	–	1	1(4.6)	–	–	–
2. Impact of intervention of Daily Living:															
(a) Very effective	1	1	2	–	–	4(17.4)	3	–	1	–	–	4(18.2)	–	–	–
(b) Effective	3	4	2	3	4	16(69.6)	2	4	3	5	3	17(77.3)	–	2	2
(c) Not every effective	1	–	–	1	1	3(13.0)	–	1	–	–	–	1(4.5)	4	–	4
3. Impact of intervention on health care:															
(a) Very effective	1	–	1	–	–	2(8.7)	2	–	–	–	–	2(9.1)	–	–	–
(b) Effective	3	4	1	2	3	13(56.5)	3	4	4	5	1	17(77.3)	–	2	2
(c) Not every effective	1	1	2	2	2	8(34.8)	–	1	–	–	2	3(13.6)	4	–	4
4. Impact of intervention on health promotion:															
(a) Very effective	1	–	–	–	–	1(4.3)	2	–	–	–	–	2(9.1)	–	–	–
(b) Effective	3	3	1	2	3	12(52.2)	3	4	4	5	–	16(72.7)	–	2	2
(c) Not every effective	1	2	3	2	2	10(43.5)	–	1	–	–	3	4(18.2)	4	–	4
5. Reasons for non-effectiveness:															
(a) Inadequate visit by KGMU team	–	2	2	1	1	6	–	3	–	–	1	4	4	–	4
(b) Short duration of the programme	1	1	1	2	2	7	–	–	–	–	–	–	4	–	4
(c) Lack of motivation	1	1	3	2	1	8	–	–	–	–	4	4	–	–	–
6. Do you still motivate the people:															
(a) Yes	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
(b) No	5	5	4	4	5	23	5	5	4	5	3	22	4	2	6
7. Reasons for not motivating them:															
(a) No incentive	5	2	4	2	4	17	2	4	1	2	1	10	4	–	4
(b) Project is completed	3	3	4	4	1	15	5	3	3	4	2	17	4	–	4

The responses received indicate that the interns are quite satisfied with the KGMU team which visited their area. Nearly 70 per cent interns from the rural and nearly 64 per cent from the urban areas of Barabanki felt that the KGMU team was good and if we add the proportion of those who felt that the team was very good we have less than 9 per cent and 5 per cent interns from the rural and urban areas respectively who have reported that the team from KGMU was average. In the case of Gorakhpur however all the 6 interns from rural as well as urban area combined felt that the KGMU team was very good.

When we asked the opinion of interns about the impact of the KGMU intervention on daily living, health care and health promotion it is observed that according to the interns of Barabanki the work done in the area of health care was effective as positive responses were received by 87 and around 95 per cent interns respectively in rural and urban areas. In the urban area however it was considered to be effective. Regarding the intervention with respect to health care and health promotion in Barabanki nearly 35 and 44 per cent interns in rural areas felt that the intervention was not effective. In the urban areas however the interns had a better opinion because a majority of them thought that intervention was effective even with respect to health care and health promotion (Table 4.2).

In the case of Gorakhpur however the interns had identical views regarding the three aspects of intervention. In the rural areas all interns felt that the impact of intervention was not effective while interns from urban areas felt it was effective.

The reasons advocated for lack of effectiveness of the impact of the intervention in rural Barabanki were pointed out as inadequate visits by the KGMU team, short duration of the programme and lack of motivation. In the urban areas the reasons cited for lack of effectiveness were inadequate visits by the KGMU team and lack of motivation. Similarly, in the rural areas of Gorakhpur inadequate visits and short duration of the intervention programme were the main reasons for its non-effectiveness.

None of the interns from either of the two districts have been motivating the control group members after the project being conducted by the KGMU was over. The reasons cited for this are that the project is over and also that there is no incentive for doing the work (Table 4.2).

The KGMU team was supposed to develop various IEC materials which were to be utilized by them as well as the interns who were to utilize them while motivating the members of the control group. In fact one set of the training and IEC modules which they claim to have developed and used was deposited in the office of the U.P. Health Systems Development Project, by the KGMU. However, neither the interns, nor the members of the control group were shown these modules let alone give it to them so that they could make use of the same. In fact the only printed material handed over to the interns were as follows:

(i) A one page pamphlet which gave a very brief information about the fact that the KGMU was carrying out an intervention, had appointed interns and had formed health clubs. It also highlighted a few aspects of daily living. The other points mentioned did not have any direct relevance to either health care or health promotion (Given at the end of the report).

(ii) One pamphlet was given to the interns showing pictoral demonstration of a few exercises which the control group members were expected to do to relieve mental tension and stress (Given at the end of the report).

(iii) For each household selected as the control group a printed family folder was given to interns. These folders kept details of the family members and a monthly account of the medical problems faced by the household members (Given at the end of the report).

From among the in interns who were selected from any given area, the KGMU team selected one member whose residence was to serve as the meeting place for the health club. The intern was supposed to get a board painted which would mention the health club. The

payment for this was to be made by the KGMU. However, not all health clubs got these boards prepared since the KGMU did not provide them funds.

In the case of Barabanki the interns put in hard work as long as the intervention project was going on. The main reason why they took so much interest was because the KGMU team had promised them that although they were not going to receive any monetary benefit initially, they would be given regular jobs if they put in hard work. It was under this illusion that the interns worked to spread awareness among the members of the control group.

Yet another reason why the work in the rural areas of Barabanki was carried out with a degree of sincerity was because the doctor attached to the PHC was very popular in his area and the KGMU team had held a meeting with him to explain the type of activity which they had planned and they had the support of the doctor as well. However, by the time our evaluation took place he had been posted out of the Harakh PHC so we could not hold discussion with him.

In the case of Gorakhpur the interns from rural area reported that despite the fact that the KGMU team did visit their area but all that they laid stress was on eating fresh food, keeping food covered and doing exercises regularly every morning. All that was done with respect to the Health Club was that its board was painted but meetings were not held on a regular basis. Despite the assurance by the KGMU team that they will keep visiting them regularly they did not do so after the three initial visits. A similar picture emerges from the urban area of Gorakhpur as well. Though the KGMU team did visit the area initially. It was because of the indifference shown by the K MU team that they too did not take their work seriously. The other factor behind lack of seriousness was that there was no incentive to do so. In a situation where the KGMU gave absolutely no incentive whatsoever to the interns it is difficult to imagine why they would take an active interest in motivating people. In Barabanki there was at least a false hope of getting a regular job if they worked hard which kept the interns motivated.

4.3 VIEWS OF THE INFLUENTIAL PEOPLE REGARDING THE INTERVENTION

In the rural areas of Barabanki we spoke to four Pradhans and had discussions with three Sabhasads in the urban areas. Besides this we also had discussion with a staff member of the PHC who has been working for some time at Harakh PHC and knew about the intervention work done by the KGMU. The doctor attached to the PHC had been posted recently and so was not aware of the type of work done by the KGMU. The points, which emerged from these discussions, are given in Table 4.3.

Table 4.3: **Views of Influential Persons about the KGMU Intervention**

Views	Village Pradhan	Sabhasad	PHC staff
1. Total Number	4	3	1
2. Did the KGMU team meet you before staring intervention			
Yes	4	3	1
No	--	--	--
3. If Yes, in what connection?			
To seek co-operation	4	2	1
To select interns	--	1	--
4. How many members were in the KGMU team?			
Upto 10	2	2	1
Above 10	2	1	--
5. Number of visits by the KGMU team in the area:			
Less than 5	3	3	1
More than 5	1	--	--
6. Were the appropriate persons appointed as interns?			
Yes	4	3	1
No	--	--	--
7. What were the duties of Interns?			
To provide health awareness	3	2	1
Help people during illness	1	1	--
8. What were he functions of the health club?			
Discuss problems arising in spreading awareness	2	1	1
No knowledge	2	2	--
9. Did the KGMU team show any display material?			
Pamphlets	4	2	1
No knowledge	--	1	--
10. Did the intervention have a positive impact?			
Yes	2	2	1
No	2	1	--
11. Are interns and health club still active?			
Yes	--	--	--
No	4	3	1

It is quite evident from the table that the KGMU team met some influential persons in each area before they began the intervention. They sought their help in selecting the interns and in some cases even the control group members. According to them the KGMU made the right selection of interns. However, not all of them were of the view that the intervention had a positive impact on the control group. They also confirmed the fact that interns and health clubs have become inactive once the project was over (Table 4.3).

To sum up, therefore, we may say that since the interns were crucial to the success of the intervention programme the KGMU made a good start by selecting educated persons as community interns. However, they were not provided proper formal training considering the

fact that they were expected to perform an important task in motivating people to improve their attitude towards daily living, health care and health promotion. Besides this they were not even provided the audio-visual IEC material which was to be an important component with the help of which the interns could make a positive impact on the members of the control group. The KGMU team was not even very regular, particularly in Gorakhpur, in visiting the selected areas and have a regular contact with the interns or the members of he control group. Consequently the interns in Gorakhpur were indifferent towards their work. To make matters worse, there was no incentive of any kind to ensure that the intern's work would be appreciated if they could produce the desired results. In fact, the KGMU team resorted to making false promises to the interns in Barabanki in order to get work done by them and since these promises were not fulfilled the interns are feeling cheated and are very critical of the KGMU team.

CHAPTER V

MAIN FINDINGS AND CONCLUSIONS

5.1 GENERAL INTRODUCTION

The present study aimed at evaluating the task undertaken by the KGMU team to carry out behaviour intervention in 500 rural and 500 urban households of Barabanki district spread over 5 villages and 5 urban localities and 25 rural and 25 urban households of one village and one urban locality each from the districts of Gorakhpur and Muzaffarnagar respectively. **For some reason no work was done in Muzaffarnagar and so our analysis revolves around the work done by the KGMU in Barabanki and Gorakhpur.**

The study was based on primary information collected from these two districts. For this three schedules were developed. The first schedule was for the control group members who were the target of the intervention work carried out by the KGMU. The second schedule was for the uncontrolled group and the third for the interns who were selected for motivating individuals. Our total sample, therefore, was as follows:

Category of Sample	Rural	Urban	Total
Control Group	140	140	280
Uncontrol Group	60	60	120
Interns	27	24	51

The objectives and research methodology have already been discussed in detail in Chapter I and so we will focus attention on the main findings of the study and then make our observations and offer our conclusions.

5.2 OUR CONTROL GROUP

It was good to observe that a majority of persons were literate. Of course, the educational qualifications were much higher among the urban households.

As far as the intervention work done by the KGMU is concerned, the majority of respondents were aware of the work done by the team led by Dr. S.C.Tewari from the KGMU. They reported that work was done in the field of daily living, health care and health promotion. The team of KGMU doctors comprised of around 6 persons and they made around four visits to both rural and urban areas. The control group was also aware of the presence of interns and the health clubs.

Despite he fact that the control group members report that the intervention work had a positive impact on them but only a much lower percentage accept the fact that they are also utilizing their knowledge in actual practice. This goes to show that he impact had only a temporary impact lasting only as long as the intervention programme was being run by the KGMU. However, one important fact which emerges is that the control group members have certainly become aware of the fact that treatment of any ailment whether minor or serious should always be treated by a qualified doctor only. Those visiting qualified doctors have shown an increase after the KGMU intervention.

Members of the control group had their own views as to whether the interns were better than the ANMs/Health workers. A relatively higher percentage were in favour of the interns. Those in favour of interns advocated that they were better since they visited their households, gave them good advise and helped them get treated in case of illness. On the other hand, those in favour of the ANM/Health workers felt that they were better since they were more qualified and properly trained and so they can provide proper guidance.

By and large, the control group members are dissatisfied with the facilities provided by government hospitals, PHCs and CHCs on the ground that there is a perpetual shortage of medicines, doctors are irregular and so the patients do not get the care that is expected in a hospital.

5.3 ANALYSIS OF THE RESPONSES OF THE MEMBERS REPRESENTING THE UNCONTROLLED GROUP

As was the case with members from the control group even among the uncontrolled group the literacy levels were high and illiterates were few. Since literacy levels are high it was not surprising to find that the awareness levels about different aspects of daily living and health care were also found among them. However, what was not so encouraging was the fact that when it comes to utilizing this awareness in their daily life, the individuals were not so serious.

Despite the fact the uncontrolled group did not have any direct link with the KGMU team a large number of them were aware of the intervention programme which was conducted and about the role played by interns in this programme. However, a relatively lower proportion of the respondents felt that the interns were effective.

Since the group consists of educated persons a high percentage are visiting a qualified doctor for treatment either in a government hospital or a private clinic.

5.4 THE COMMUNITY INTERNS AND THEIR ROLE IN INTERVENTION

The interns, as has been indicated in Chapter IV were crucial to the success of the behaviour intervention programme. This was so because they were the ones to spread

awareness among the control group members on the various aspects related to daily living health care and health promotion. The KGMU team could at the most make a few visits to each selected location. Thus the success of the programme revolved around the sincerity and dedication put in by the interns. Since they were selected from the same village and urban locality from which the control group members were identified it was expected the interns would maintain regular contact with the control group and keep extending their help.

On an average the KGMU selected 4-5 interns from each location both rural and urban. Since they were expected to perform an important role care was taken by the KGMU team to select educated persons to work as interns. As a result the interns in both districts were well educated. However, one thing where the KGMU team did not pay sufficient attention was on providing them proper formal training. They were only briefed about their role before asking them to assist in the intervention programme. On an average each intern was to look after 20-25 members from the control group. Besides selection of these interns the KGMU team also formed health clubs in each location and all the interns of the area were its members. They were expected to meet in these clubs and discuss the problems, which they were facing while spreading awareness among the control group, and to sort out these problems among themselves and also with the help of the KGMU team when it visited their area. While the interns took their work seriously in the rural as well as urban areas of Barabanki, the same was not true in the case of Gorakhpur where the interns report that the KGMU team did not show enough interest themselves in the work they were doing.

Yet another area where the KGMU team did not perform its task effectively was in providing the IEC material as had been indicated by them. They did develop a number of posters and other IEC material but it did not reach the interns. In fact all that the interns were given were:

(i) A single page pamphlet indicating the work being doe by KGMU and a few tips related to daily living.

(ii) A pamphlet indicating a few exercises which the control group members were supposed to do regularly to relieve them from any stress.

(iii) A printed Family Folder, which the interns were to keep for each family. This kept record of the details of the household and a monthly account of the illness which may have been reported by the households.

The KGMU team in the case of Barabanki also committed the mistake of giving false promises to the interns of both rural and urban areas. They were promised a regular job once the project was over provided they worked hard and made the intervention programme a successful one.

5.5 VIEWS OF THE INFLUENTIAL PERSONS

In order to obtain further information about the intervention work we also held discussions with some influential persons like the Sabhasad and Pradhan in order to obtain their perception regarding the work done by the KGMU. They informed that the KGMU team had met them before they began their work and sought their co-operation to ensure community participation and in the selection of interns. According to majority of them the KGMU team made about 5 visits to the area and that the interns selected by them were appropriate for the job. The opinion was divided among them regarding the impact made by the intervention.

Another fact, which emerges is that, the interns and the health clubs were working only as long as the KGMU project was going on. And they are now totally inactive.

5.6 CONCLUSIONS

The KGMU team carried out work related to behaviour intervention in the districts of Barabanki and Gorakhpur. For this they selected five villages from Harakh block and five urban localities in the case of Barabanki. From Gorakhpur they had selected the village of Araji Chauri and the urban Mohalla of Humayunpur. However, although it was indicated that in the case of Muzaffarnagar they had selected the village of Pachenda Kala and the urban Mohalla Brahmpuri, the KGMU made just one visit to each of these places.

Brahmpuri is a posh locality of Muzaffarnagar and from this locality they met Dr. Ranjit Singh who is a doctor and also runs an NGO by the name *Lok Kalyan Samiti*. From Dr. Ranjit Singh they got the names of Dr. Harbeer Singh and Mr. Mohammad Rafeeq. They were included along with Dr. Ranjit Singh as their interns for the urban area. But neither Dr. Harbeer Singh nor Mr. Mohammad Rafeeq were told that they have been appointed as interns. In fact the KGMU team did not even meet them. Besides this Dr. Ranjit Singh was requested to invite some individuals living in the vicinity of his residence and these are some names which figure in their list of control group members indicated by the KGMU. However, no discussion regarding the intervention work was held. Dr. Ranjit Singh was given a few posters and was asked to get a board painted indicating the existence of the Health Club. The KGMU team promised to come later to initiate the intervention programme. But they failed to come back.

Similarly in the case of Pachenda Kala village, which is on the outskirts of Muzaffarnagar a five member team from KGMU met the ex-Pradhan and asked him to collect a few villagers who they could talk to. With these people the team spent a couple of hours and gave them a general lecture about cleanliness. Those who were present during this discussion were listed as members of the control group and a few were selected as interns. However, from among those selected as interns only Shri Satyendra Kumar was aware of the fact that he had been selected

as Intern. The KGMU team promised to return with other doctors to create awareness among the villagers regarding health care. However, no second visit was made by them.

We managed to contact 16 members from the list given as control group members from Pachenda Kala and 15 from the list of control group members indicated from Brahmpuri and they all confirmed that **no work related to behaviour intervention was carried out in Muzaffarnagar by the KGMU. Consequently, our analysis revolves around the information collected by us from Barabanki and Gorakhpur only.**

Even between the two districts of Barabanki and Gorakhpur the main effort put in by the KGMU team was concentrated in Barabanki district. The reasons for this are obvious. In the first place Barabanki was the sole district which they had identified for the purpose of their study. Therefore, they had selected a large sample covering 500 households each from the rural and urban areas. The fact that Barabanki is so close to Lucknow it was always going to be easy for them to control the project. Reaching any selected location of Barabanki from Lucknow is convenient ad the distances can be covered in around an hour or so. Consequently it was possible for the KGMU to make a number of visits comprising of many team members. Gorakhpur and Muzaffarnagar were added later on and that probably explains why the sample covered only one village from each of the two districts and one urban locality to represent Gorakhpur and Muzaffarnagar. Moreover only 25 households were identified from each location. While Muzaffarnagar is well over 400 kilometres from Lucknow, even Gorakhpur is over 200 kilometres. It was, therefore, not easy to control the work even in Gorakhpur. This, therefore, explains why the work was done more seriously in Barabanki alone.

In both the districts of Barabanki and Gorakhpur a majority of the people from the control group remembered that the KGMU team had visited their village and discussed various aspects of daily living health care and health promotion.

They were also aware of the fact that the KGMU had appointed community interns and formed health clubs in order to promote awareness among the control group. They were generally happy with the work done by the interns. In fact a large number are of the opinion that the interns did a better job than the ANM or health workers who are appointed by the government. However, the others felt that the ANM/health workers are better as compared to the community interns.

The control group members are generally of the opinion that the intervention work had a positive impact on them. However, while the proportion of such individuals may be high, those who also accept that they are utilizing this awareness in their daily life are in a smaller proportion. This goes to show that the impact was being felt so long as the project work was going on and the interns were visiting the control group members with some degree of

regularity. Unfortunately, as soon as the project was over the interns stopped working and so also the health clubs became dysfunctional. However, one thing which is a definite plus point is that if we look at the situation before and after the intervention, it is found that in the post intervention period a larger proportion of the control group members have been going for treatment to qualified doctors either in the government hospital or in a private hospital or clinic as compared to before the intervention.

One of the reasons why people have reported a high impact of the intervention is because a high percentage of our sample from both rural and urban areas is literate. This clearly highlights the fact that if any programme is to achieve success it is positively correlated with the educational levels of the target group. As a result we find that awareness about daily living, health care and health promotion was relatively higher among the people from urban areas.

By virtue of the fact that levels of education are high and illiterates constituted a low percentage of the total sample from among the uncontrolled group as well, even they were aware of the different aspects of daily living and health care despite the fact that the KGMU team did not have a direct contact with them. They had knowledge of the intervention work done by the KGMU and some even accepted that they too have benefitted by the intervention by coming into contact with either the interns or the control group members. Even this section of our sample is mainly aware of the fact that treatment should be taken only from qualified doctors.

There appears to be no distinct difference between the respondents from control and uncontrol groups if we look at the levels of awareness between them regarding the different aspects related to daily living and health care. This becomes clear if we look at the table being presented below.

Table 5.1 **Comparative picture of levels of awareness among Control and Un-Control Groups regarding Daily living and Health Care**

Details	Control Group				Uncontrol Group			
	Barabanki		Gorakhpur		Barabanki		Gorakhpur	
	Rural	Urban	Rural	Urban	Rural	Urban	Rural	Urban
Daily Living	(125)	(125)	(21)	(16)	(50)	(50)	(10)	(10)
Smokeless Kitchen	58 (46.4)	89 (71.2)	7 (33.3)	10 (62.5)	25 (50.0)	35 (70.0)	4 (40.0)	4 (40.0)
Cleanliness While Cooking	61 (48.8)	101 (80.8)	11 (52.4)	9 (56.3)	36 (72.0)	43 (86.0)	7 (70.0)	5 (50.0)
Cleanliness inside and outside house	77 (61.6)	91 (72.8)	10 (47.6)	7 (43.8)	33 (66.0)	44 (88.0)	6 (60.0)	6 (60.0)
Proper ventilation	62 (49.6)	80 (64.0)	7 (33.3)	5 (31.3)	27 (54.0)	38 (76.0)	3 (30.0)	5 (50.0)
Balance Diet	47 (37.6)	92 (73.6)	9 (42.9)	8 (50.0)	17 (34.0)	43 (86.0)	5 (50.0)	5 (50.0)
Safe Drinking Water	100 (80.0)	92 (73.6)	11 (52.4)	6 (37.5)	36 (72.0)	42 (84.0)	8 (80.0)	7 (70.0)
On Health Care								
Treatment without delay	69 (55.2)	103 (82.4)	4 (19.0)	8 (50.0)	36 (72.0)	37 (74.0)	7 (70.0)	6 (60.0)
Treatment only from qualified doctors	60 (48.0)	97 (77.6)	6 (28.6)	7 (43.8)	37 (74.0)	40 (80.0)	6 (60.0)	7 (70.0)
AIDS awareness	39 (31.2)	66 (52.8)	3 (14.3)	7 (43.8)	21 (42.0)	25 (50.0)	3 (30.0)	3 (30.0)
Knowledge of family planning	70 (56.0)	90 (72.0)	5 (23.8)	8 (50.0)	27 (54.0)	36 (72.0)	8 (80.0)	6 (60.0)
Regular exercise	43 (34.4)	74 (59.2)	5 (23.8)	4 (25.0)	24 (48.0)	34 (68.0)	4 (40.0)	5 (50.0)
Avoid tension	35 (28.0)	92 (73.6)	2 (9.5)	6 (37.5)	18 (36.0)	26 (52.0)	3 (30.0)	3 (30.0)
Evils of Drug addiction	58 (46.4)	87 (69.6)	8 (38.1)	5 (31.3)	31 (62.0)	38 (76.0)	7 (70.0)	6 (60.0)

In the case of the control group the respondents have indicated the positive response which they have felt as a result of the behaviour intervention. On the contrary the uncontrol group were asked about this awareness regarding the same aspects related to daily living and health care. Thus the table clearly highlights the fact that there is not much to choose from between the two groups of individuals.

The KGMU started the intervention work on a correct note by selecting educated persons for the work of community interns. However, they did not bother to give them any formal training which would have made the task of spreading awareness that much more easier. A proper training would have given them better insight into the different aspects of daily living, health care as well as health protection on one hand and on how to approach the control group members to be able to convey this message on the other. A casual approach was adopted by the KGMU and whatever little training was given was highly informal and did not serve the desired purpose. This is reflected in the fact that although the control group members accept the fact that the intervention had a positive impact on them, they are not seriously utilizing their knowledge in their day to day activities. In fact some have even reported that they are not interested in changing their life style and this does not speak very well of either the attitudes of the people nor of the effort put in by the KGMU and the team of interns.

Not only were the interns not given any formal training they were not even provided with the IEC material which was supposed to have been developed by the KGMU team for this purpose. Our enquiry from both members of the control group as well as the interns clearly revealed that the IEC material was conspicuous by its absence. The only material provided to the interns were one pamphlet indicating the intervention work being undertaken by the KGMU, the presence of interns and health clubs and some very simple aspects of daily living. Besides this a second pamphlet distributed among interns showed pictoral demonstration of a few exercises which are useful in reducing stress. Besides this the KGMU team distributed Family Folders which each intern was expected to maintain of each and every household from the control group under his care.

Yet another aspect which was lacking was that although the interns were to play such a significant role in the intervention process there was absolutely no incentive for them to work hard and sincerely. In fact, in the case of Barabanki the interns put in really hard work on the false hope given to them that their hard work would be rewarded by giving them a regular job once the project was over and in case their work was found satisfactory. As a result this group of interns is a highly dejected lot and feels that it was cheated by the KGMU team.

The influential person like Village Pradhan and Sabhasad, etc. were fully aware of the work done by the KGMU team. They had actually been contacted before the intervention work was initiated and their help was taken in obtaining co-operation of the community as well as in the identification of interns. However, even these persons are divided in their opinion as far as the utility of the interns and effectiveness of the intervention programme is concerned.

Finally we may say that the intervention programme had achieved a reasonable degree of satisfaction among the members of the community as revealed in their statement that it had a positive impact on them. However, the impact was not a lasting one and once the project was over the interns as well as the health clubs became non-functional and a large number of people have gone back to their old ways. We have a classic case where a female intern from the rural area of Barabanki frankly admitted the fact that so long as she was actively working as intern her own father was seriously making efforts to give up smoking. However, as soon as the work was over her father has resumed smoking at the same old rate. The KGMU spent quite a sizeable amount on the intervention work and the results do not speak very highly in favour of its cost effectiveness.

The work of interns can not be a success so long as we want them to function merely as workers for a social cause. There has to be an incentive of some sort if they are to work sincerely. Moreover, we already have the ANM and health worker appointed by the

government. They can easily be asked to spread awareness among the people and inculcate a proper attitude among them with respect to health care, health promotion and daily living.

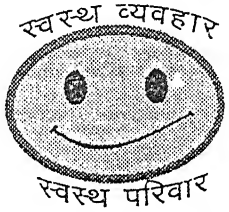
Since the work done by the KGMU related to spreading awareness in general about health care and daily living, the facts reveal that in the rural areas in particular there are only around twenty-five per cent individuals who are utilizing this knowledge in their daily lives. In the urban areas the percentage is somewhat higher at around 42 per cent and this too is far from being impressive. This itself gives an indication towards the fact that not much impact has been made in the morbidity levels either.

ANNEXURE No. 1

यह कोई विज्ञापन नहीं, किसी खर्च की अपेक्षा भी नहीं

कुछ उपयोगी विवरण : पढ़ें, ध्यान दें, ग्रहण करें।

न कोई खर्च न कोई फिल्लत



स्वस्थ व्यवहार ही करे जीवन उन्नत

प्रिय बाराबंकीवासियों

हममें से शायद ही कोई होगा जो उपरोक्त कथनो से सहमत न हों। पर हममें से कितने इराका ध्यान रखते हैं, इसे अपनाते हैं। हम जानते हैं कि हमारे रहन सहन व दिनचर्या में गड़बड़ी, अनुपयुक्त आदतें व आचार विचार हमारी स्वस्थता व खुशहाली में गिरावट लाते हैं।

हम सभी यह भी जानते हैं कि जनसमुदाय मे मानसिक व शारीरिक रोगियों की सतत् वृद्धि हो रही है। लोग अधिक तनावग्रस्त, चिन्ताग्रस्त उदास व थके थके दिखायी पड़ते हैं। चिकित्सा उपचार पर होने वाले व्यय में तुलनात्मक वृद्धि हो रही है। यदि हम नियम संयम से रहें तो बीमार पड़ने या जीवन स्तर में अवनति की सम्भावनाएँ नगण्य रहेंगी। वस्तुतः स्वस्थता और अच्छे जीवन की सर्वाधिक जिम्मेदारी हमारी स्वयं की ही है। आज का संदेश है – *"नियम संयम रूपी सुरक्षा कवच अपनाइये : स्वयं, परिवार, समुदाय व देश की प्रगति का मार्ग प्रशस्त कीजिए"।*

इसी संदेश को प्रचारित/प्रसारित करने के लिए जनपद बाराबंकी के पांच ग्रामीण व पांच शहरी क्षेत्रों में व्यवहार मध्यस्थता परियोजना चलाई जा रही है जिसमें सी० एस० एम० मेडिकल यूनिवर्सिटी, लखनऊ के मनोचिकित्सा विभाग से प्रो० एस० सी० तिवारी के निर्देशन में एक रिसर्च टीम कार्यरत है जिसने प्रत्येक क्षेत्र में लगभग 100 परिवारों से सम्पर्क कर उन्हें अपने दैनिक रहन सहन एवं आचार विचार, चिकित्सा उपचार व स्वास्थ्य वर्धन के संबंध मे उपयुक्त परिवर्तन लाने की सलाह दी है जिसके अत्यन्त उत्साहवर्धक परिणाम निकले है । प्रत्येक क्षेत्र में एक *हेल्थ क्लब* की स्थापना भी की गई है जहाँ कार्यरत स्थानीय स्वैच्छिक कार्यकर्ताओं *(सामुदायिक मित्र)* को व्यवहारिक मध्यस्थता संबंधी मूलभूत प्रशिक्षण व जानकारी भी दी गई है। प्रत्येक क्षेत्र में *सामुदायिक मित्र* परियोजना में प्रतिनिधि का कार्य करते हैं।

आप भी अपने प्रतिकूल आचार विचार, तौर तरीको, स्वभाव व आदतों में परिवर्तन ला सकते हैं, उन्हें अनुकूल बना सकते हैं, अपनी शैली व स्वस्थता स्तर में सुधार ला सकते हैं। *प्रयास कीजिए आप कर सकते हैं। अपने से वादा कीजिए, दूसरे को भी बढ़ावा दीजिए।*

ध्यान रहे :

- दिनचर्या नियमित रखें ।
- हल्का व्यायाम करें।
- व्यक्तिगत साफ सफाई का ध्यान रखें।
- अपने पर विश्वास रखें।
- खुली ताजी हवा के सेवन हेतु सुबह टहलें।
- व्यक्तिगत सीमाओं को नजर अन्दाज करने की आदत न डालें।
- अपनी क्षमताओं को जीवनयापन का आधार बनावें।
- आप आज जो भी है आपमें उससे और अच्छा बनने की क्षमता है।
- कोई भी व्यय करने से पूर्व सोचें कि क्या यह व्यय किये बगैर आपका काम चल सकता है। यदि उत्तर मिले कि "हाँ" तो उस व्यय को यथा सम्भव न करें।
- संसार में सभी को सभी कुछ नहीं मिल पाता। आपके पास जो कुछ है उसके लिये अपने इष्टदेव को धन्यवाद दें!
- दूसरों के साथ ऐसा व्यवहार न करें जो आप नहीं चाहते कि दूसरे आपके साथ करें ।
- सोने जाने से पूर्व स्वंय से पूछें : आज आपका दिन कैसा बीता? जो भी उत्तर मिले उसका कारण खोजे और उसमें निरन्तर सुधार लाने की चेष्टा करें।
- क्रमिक थकाऊ शारीरिक/मानसिक श्रम से बचें।
- कर्म प्रधान है । उत्तम कर्म उत्तम पौष्टिकता ।
- किसी भी काम में हड़बड़ी न कीजिए : दुर्घटना से देर भली।
- याद रखिये : सब दिन एक समान कभी नही रहते।
- आहार की पौष्टिकता पर ध्यान दें।
- कथनी और करनी में यथा सम्भव दूरी कम कीजिए : समस्यायें घटेगी।
- लक्ष्य प्राप्ति के लिए जो संभव हो सके करना प्रारम्भ कीजिए। एकाएक आपको लगेगा कि आपने असम्भव को सम्भव कर डाला।
- जीवन के महत्वपूर्ण निर्णय केवल दिल या केवल दिमाग से ही न ले।
- भूल चूक, आवेशी, बाध्यता व्यवहार पाप नही होते : इनकी पुनरावृत्ति से बचे ।
- भविष्य के गर्त में उन्नति ही है, अवनति नही। जागिए और चलिए।
- अपनी क्षमताओं/योग्यताओं का भरपूर उपयोग न करना अपने इष्टदेव का अनादर है।

□□□□□

☺ मानसिक चिकित्सा विभाग, सी.एस.एम. मेडिकल यूनीवर्सिटी, लखनऊ – 226 003 (दूरभाष : 2268857) द्वारा जनहित में प्रसारित।

ANNEXURE No. 2.

Study of the Impact of Behavioural Intervention on illness Breeding Behaviours (U.P.H.S.D.P., Lucknow)

Department of Psychiatry, C.S.M. Medical University, Lucknow

"स्वस्थ तन स्वस्थ मन
किश्त आपकी–बीमा हमारा"

दैनिक जीवन में सब कुछ हमेशा वैसा ही नहीं होता जैसा हम चाहते हैं। सुख दुख, चैन उलझन, स्वस्थता अस्वस्थता किसकी झोली से बाहर हैं ? यह बात अलग है कि किसकी झोली में क्या ज्यादा है और किसकी में क्या कम। क्या कभी हमने ईमानदारी से सोचा है कि जो कुछ हमारी झोली में है उसके लिये हम स्वंय कितने जिम्मेदार हैं । जो हमारे पास है उसके लिये तो मुख्यतः हम जिम्मेदार हैं ही , जो हमारे पास नहीं है उसके लिये भी काफी सीमा तक हम स्वंय ही जिम्मेदार हैं। अपवादों को छोड़ दें तो जन्म के समय ईश्वर ने सभी को लगभग समान शारीरिक बौद्धिक और चारित्रिक सम्पदा दी है परन्तु सभी की उपलब्धियां, समायोजन क्रिया कलाप समान नहीं होते। काफी सीमा तक इस असामनता का कारण "व्यक्ति स्वंय में क्या है क्या नहीं है' में देखा जा सकता है।

प्रायः कुछ क्षेत्र ऐसे है जिनमें हम परिवर्तन ला सकते है। रहन सहन, व्यवहार, क्रिया कलाप इन क्षेत्रो में प्रमुख है जिनमें बिना विशेष कठिनाई के परिवर्तन लाया जा सकता है यदि परिवर्तन से जनित लाभों की जानकारी हो, इच्छा हो और अपने पर विश्वास हो। जीवन की गुणवत्ता अधिकांशतः इन्ही क्षेत्रो पर निर्भर होती है । जितना समायोजित रहन सहन, क्रिया कलाप, व्यवहार उतना ही सुख, समृद्धि व स्वस्थता । 'बचाव' कवच है जो शारीरिक / मानसिक विकारों से बचाता है । छोटी छोटी सावधानियां अपनावें, बड़ी समस्याओं से बचें । बचाव रूपी किश्त नियमित जमा करें : स्वास्थता स्तर एवं जीवन की गुणवत्ता में सुधार का बीमा हमारा । कवच की मजबूती के लिये "क्या करें/'क्या न करें"* अच्छा लिए। कीजिए, आप कर सकते है। रखिये

क्या करें / क्या न करें *

1- दिनचर्या नियमित रक्खें ।
2- आहार की पौष्टिकता पर ध्यान रक्खें ।
3- खुली ताजी हवा के सेवन हेतु सुबह टहलें।
4- हल्का व्यायाम करें। संलग्नित चित्रों के अनुसार प्रयास करे। आवश्यकतानुसार सलाह लें।
5- व्यक्तिगत साफ सफाई का ध्यान रक्खें ।
6- क्रमिक थकाऊ शारीरिक / मानसिक श्रम से बचे।
7- व्यक्तिगत सीमाओं को नजरन्दाज करने की आदत न डाले।
8- ध्यान रक्खे : बचाव / रोकथाम में गड़बड़ी या कमी से बीमारी रूपी बिन बुलायें मेहमान की दस्तक को आमंत्रण हैं।
9- अपने पर विश्वास रक्खें ।
10- संसार में सभी को सभी कुछ नहीं मिल पाता । आपके पास जो कुछ है उसके लिये अपने इष्टदेव को धन्यवाद दें।

11- अपनी कमजोरियों को जीवन यापन का आधार न बनावें।

12- अपनी क्षमताओं को पहचाने, समझे तथा उसे अपनी महत्वकांक्षा स्तर निर्धारण का आधार बनावें।

13- दूसरों के साथ ऐसा व्यवहार न करें जो आप नहीं चाहते कि दूसरे आपके साथ वैसा व्यवहार करे।

14- कोई भी व्यय करने से पूर्व सोंचे कि क्या यह व्यय किये बगैर आपका काम चल सकता है। यदि उत्तर मिले कि "हाँ" तो उस व्यय को यथा सम्भव न करें।

15- बचत सुरक्षा भाव उत्पन्न करती है। यथा सम्भव बचत करने की आदत डालें।

16- सोने जाने से पूर्व स्वंय से पूंछे "आज आपका दिन कैसा बीता" ? यदि उत्तर मिलता है कि "अच्छा" तो स्वंय से जानकारी लें : "क्या इसे और अच्छा बनाया जा सकता हैं" ? यदि उत्तर मिले कि "हाँ" तो विचार करें कि कैसे ? यदि प्रारम्भिक प्रश्न के उत्तर में आपका मन कहता है कि "अच्छा नहीं" तो अपने आप को बतावें कि ऐसा सोचने के क्या कारण हैं ?

17- जीवन के महत्वपूर्ण निर्णय केवल "दिल" या केवल "दिमाग" से ही न ले । दोनो के सम्यक योगदान को निर्णय का आधार बनावें।

18- भूल चूक, संवेगी या बाध्यता व्यवहार पाप नही होते । हम आप सभी के साथ ऐसा हो सकता है । श्रेष्ठ वे है जो इनसे सीख लेते है तथा भविष्य में इनकी पुनरावृत्ति से बचते हैं ।

19- आपकी क्षमतायें / योग्यतायें ईश्वरीय देन है। उनका भरपूर उपयोग न करना अपने ईष्ठदेव का अनादर है।

20- आप आज जो भी है आपमें उससे और अच्छा बनने की क्षमता है।

21- बचाव उपचार लेने की अवस्थिति से बचाता है।

22- संसार में प्रत्येक नवजात शिशु ईश्वर की यह भावना दर्शाता है कि वह मानव जाति से प्रसन्न है। अपनें व्यवहार से उसे अप्रसन्न न करें।

23- कर्म प्रधान है। इससे फल की पौष्टिकता निर्धारित होती है। उत्तम कर्म–उत्तम पौष्टिकता ।

24- किसी भी काम में हड़बड़ी न कीजिए : दुर्घटना से देर भली।

25- लक्ष्य प्राप्ति के लिए जो सम्भव हो सकें करना प्रारम्भ कीजिए। शीघ्र ही उसके लिए जो आवश्यक है उसे करने में आपको अधिक विलम्ब नही लगेगा । फिर एकाएक आपको लगेगा कि आपने असम्भव कर डाला।

26- जरा सोचिये : आपके साथ जो कुछ हुआ या हो रहा है उसमे भी खराब हो सकता था। जो है उसमें भी अच्छाई देखिये । आपमें हिम्मत बढ़ेगी।

27- याद रखिये सब दिन एक समान कभी नही रहते।

28- "कथनी और करनी" में यथा सम्भव कम से कम दूरी रखने का प्रयास कीजिए। समस्यायें घटेंगी।

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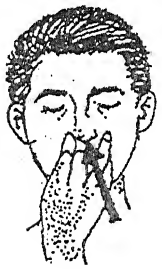
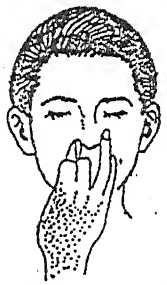
Distributed to households in Behavioural Intervention Programme.

C: Ashok/Dr.Aditya-23-10-02

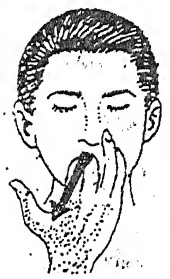
मानसिक तनाव कम करने के व्यायाम



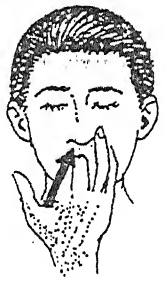
1. अंगूठे से दाएं नासिका छिद्र को बंद रखते हुए बाएं नासिका छिद्र से सांस लें।



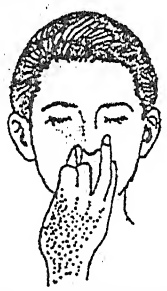
2. दोनों नासिका छिद्र बंद करके सांस रोकें।



3. दाएं नासिका छिद्र से सांस बाहर छोड़ें। बायां नासिका छिद्र अनामिका व कनिष्ठा उंगली से बंद रखें



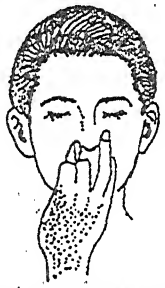
4. अब बायां नासिका छिद्र बंद रखते हुए दाएं से सांस लें।



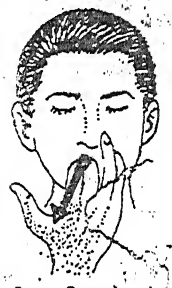
5. दोनों नासिका छिद्र बंद करके सांस रोकें।

6. बाएं नासिका छिद्र से सांस बाहर छोड़ें। दायां नासिका छिद्र अंगूठे से बंद रखें।

7. अंगूठे से दाएं नासिका छिद्र को बंद रखते हुए बाएं नासिका छिद्र से सांस लें।

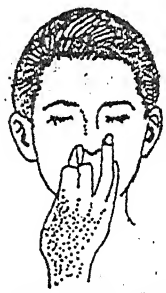


8. दोनों नासिका छिद्र बंद करके सांस रोकें।



9. दाएं नासिका छिद्र से सांस बाहर छोड़ें। बायां नासिका छिद्र अनामिका व कनिष्ठा उंगली से बंद रखें।

10. अब बायां नासिका छिद्र बंद रखते हुए दाएं से सांस लें।



11. दोनों नासिका छिद्र बंद करके सांस रोकें।

12. बाएं नासिका छिद्र से सांस बाहर छोड़ें। दाया नासिका छिद्र अंगूठे से बंद रखें।

सूर्य नमस्कार

सूर्य नमस्कार से लाभ :-

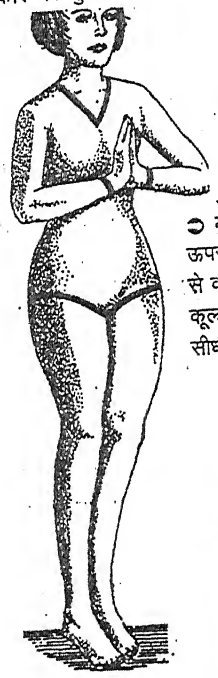
पुराणों में सूर्य को शक्ति और स्वास्थ्य के देवता के रूप में पूजा गया है। सूर्य का पुजारी सूर्य की भाँति कीर्तिवान, तेजस्वी एवं शक्तिशाली होता है। सूर्य उदय के समय सूर्य नमस्कार करने के निम्न लाभ हैं।

सूर्य नमस्कार सभी आसनों का आधार है। इसे करने से शरीर लचीला बनता है तथा अन्य आसनों के लिए तैयार होता है।

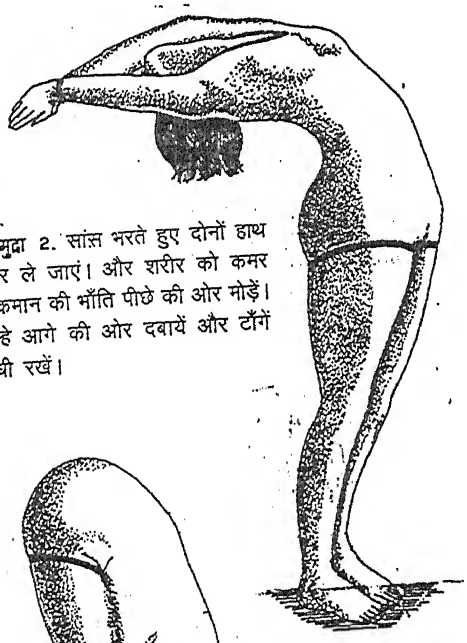
सूर्य नमस्कार से श्वांस सम्बन्धी तकलीफें दूर होती हैं।

मोटापा कम होता है।

रीढ़ की हड्डी व जोड़ों का दर्द दूर होता है। अमाशय, जिगर, गुर्दे तथा छोटी और बड़ी आंतों को बल मिलता है।



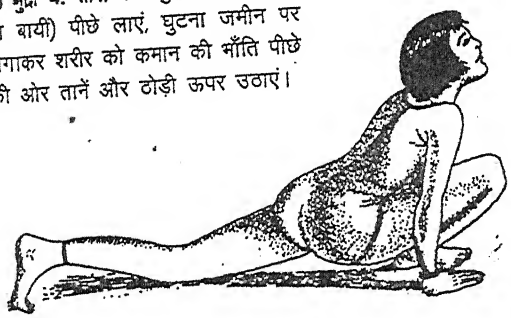
मुद्रा 1. सीधे खड़े होकर हथेलियाँ नमस्कार की मुद्रा में जोड़ें।



मुद्रा 2. सांस भरते हुए दोनों हाथ ऊपर ले जाएं। और शरीर को कमर से कमान की भाँति पीछे की ओर मोड़ें। कूल्हे आगे की ओर दबायें और टाँगें सीधी रखें।

मुद्रा 3. सांस छोड़ते हुए आगे झुकें, हाथों का दबाव फर्श पर। हथेलियाँ दोनों पाँवों के समानान्तर। आवश्यक हो तो घुटने मोड़ें।

मुद्रा 5. सांस रोके हुए दूसरी टांग भी पीछे लाएं। शरीर का सम्पूर्ण भार हथेलियों व पैर कें पंजों पर। सिर व शेष शरीर एक रेखा में और आँखें दोनों हाथों के मध्य स्थान पर केन्द्रित करें।

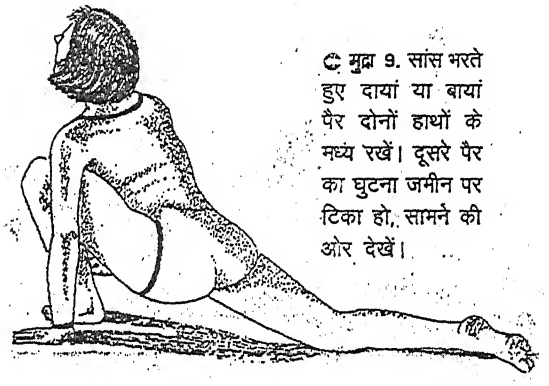


मुद्रा 4. सांस भरते हुए एक पैर (दायीं या बायीं) पीछे लाएं, घुटना जमीन पर लगाकर शरीर को कमान की भाँति पीछे की ओर तानें और ठोड़ी ऊपर उठाएं।

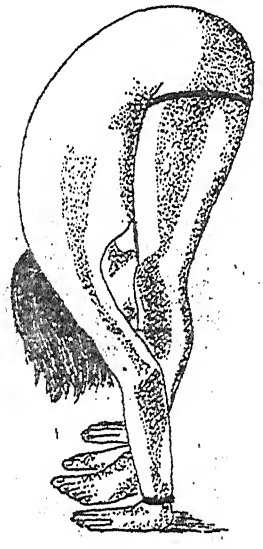
मुद्रा 6. सांस छोड़ते हुए घुटने नीचे लाएं, फिर क्रमशः छाती और मस्तक को भी जमीन पर टिकाएं। नितम्ब उठे हुए। पंजो को अन्दर की ओर मोड़ें।

मुद्रा 7. सांस भरते हुए नितम्बों को नीचे लाएं, दोनों पंजे जोड़ें और पीछे की ओर फैलाएं। दोनों हाथों को सीधे रखते हुए शरीर कमान की भांति पीछे की ओर मोड़ें। कंधे नीचे की ओर दबाएं। ऊपर और पीछे देखने का प्रयास करें।

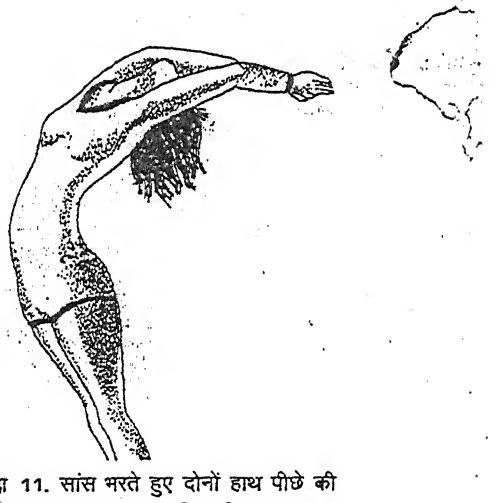
मुद्रा 8. सांस छोड़ें, पंजे अन्दर के ओर दबाएं, नितम्ब ऊपर की ओर उठाने का प्रयास करें। एड़ी और सिर को नीचे झुकाने की कोशिश करें। कंधे पीछे की ओर दबाएं।



मुद्रा 9. सांस भरते हुए दायां या बायां पैर दोनों हाथों के मध्य रखें। दूसरे पैर का घुटना जमीन पर टिका हो, सामने की ओर देखें।



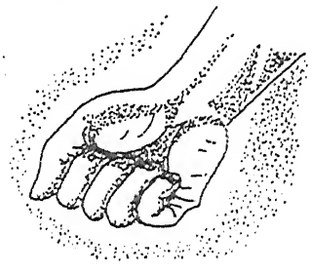
मुद्रा 10. सांस छोड़े, दूसरा पैर भी आगे लाएं और कमर से सिर तक का भाग नीचे झुकाएं। हथेलियों का दबाव फर्श पर।



मुद्रा 11. सांस भरते हुए दोनों हाथ पीछे की ओर ले जाएं। शरीर कमान की भांति तना हुआ।

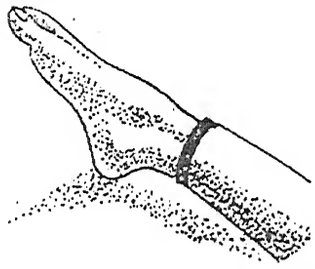
पूर्ण शवासन

मुद्रा 1. पीठ के बल लेट जाइए। दोनों पांवों के बीच लगभग डेढ फीट की दूरी रखें। हाथों को शरीर से 6 से 8 इंच दूर रखें। हथेलियाँ ऊपर की ओर रखें। पाँव के पंजे, घुटने तथा जांघ का भार बाहर की ओर डालें। अब आँखें बंद कीजिए और गहरी सांस लीजिए।



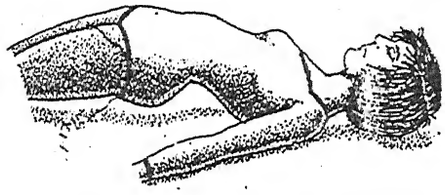
मुद्रा 2. अपना एक हाथ जमीन से एक इंच ऊपर उठाएं। मुटठी बंद करें, बाँह को तानें, फिर नीचे गिरने दें। यही क्रिया दूसरे हाथ से दोहराएं।

मुद्रा 3. मुँह को खोलें। आँखें फैलाएं, और अपनी जीभ जितनी संभव हो सके, बाहर निकालें।



मुद्रा 4. अपनी दाईं टांग जमीन से एक इंच ऊपर उठाएं। उसे तानें, राकें, फिर नीचे गिरने दें। यही क्रिया बाईं टांग से दोहराएं।

मुद्रा 2. दाँतों को इस प्रकार भीचें कि चेहरे की हर मांसपेशी तन जाए।



मुद्रा 5. नितम्बों को सख्ती से जोडत्रते हुए जमीन से जरा ऊपर उठाएं, रूकें, फिर नीचे ले जाएं।

मुद्रा 7. कंधो को उठाएं और गर्दन की ओर ले जाकर तानें, फिर नीचे आने दें।

मुद्रा 6. छाती को इस प्रकार ऊपर उठाऐं कि आपका सिर व नितम्ब जमीन पर लगे रहें। तनाव दें, फिर नीचे आने दें।

⇨ *Issued in Public Interest.*

ANNEXURE No 5

बिहेवियर इन्टरवेंशन प्रोजेक्ट

स्वस्थ व्यवहार रखे स्वस्थ परिवार

फेमिली फोल्डर

कम्यूनिटी इनटर्न
नाम : नीलम निगम
कोड न0 :

संयोजक :

- मानसिक चिकित्सा विभाग, छत्रपति शाहूजी महाराज चिकित्सा विश्वविद्यालय, लखनऊ।
- उत्तर प्रदेश हेल्थ सिस्टम डेवलेपमेन्ट प्रोजेक्ट, इन्दिरा नगर, लखनऊ।

संपर्क : *डा0 एस0 सी0 तिवारी / डा0 आदित्य कुमार,*

मानसिक चिकित्सा विभाग, छत्रपति शाहूजी महाराज चिकित्सा विश्वविद्यालय, लखनऊ।

दूरभाष : **0522-2268857** मोबाइल : **9415011977**

BIP Project - Family Folder

ग्राम/मोहल्ला : [illegible] परिवार की पहचान : [illegible]

परिवार के मुखिया का नाम : श्री शम्भू शरण गिरि

1- पारिवारिक विवरण :

क्रम सं०	परिवार के सदस्यों का नाम	उम्र	शैक्षिक स्तर	व्यवसाय	स्वास्थ्य स्तर		
					वर्तमान स्वास्थ्य	तीन माह बाद स्वास्थ्य	6 माह बाद स्वास्थ्य
1.	श्री शम्भू शरण गिरि	50yr	5	नौकरी	स्वास्थ्य 1	1	
2.	उमाशंकर	28 "	V	~~व्यवसाय~~ व्यापार	"	1	
3.	श्रीमती पुष्पा देवी	25 "	VIII	गृहणी	"	1	
4.	निधि	6 "	III	शिक्षारत	"	1	
5.	सौरभ	4 "	I	"	"	1	
6.	छोटू	3 "	Nursery	"	"	1	
6.	श्री राजेश गिरि	22 "	B.A.	अध्यापक	"	1	
7.	श्रीमती श्यामा देवी	20 "	XII	गृहणी	"	1	
8.	अरविन्द कुमार गिरि	18 "	[illegible]	शिक्षारत	"	1	
9.	रवीन्द्र कुमार गिरि	16 "	"	"	"	1	
10.	[illegible]	2½ "	गृह शिक्षा	"	"	1	

स्वास्थ्य स्तर की रेटिंग : 0- खराब ; 1- सामान्य ; 2- अच्छा

यदि रेटिंग 0 या 2 है तो विवरण दें

2- वी. आई. पी कार्यक्रम के फलस्वरूप आपके स्वास्थ्य पर क्या प्रभाव पड़ा है ?

0		

रेटिंग : 0- अनुकूल ; 1-कूछ भी नही ; 2- प्रतिकूल

ऐसा कहने का कारण हैं :

3- इस कार्यक्रम को और कारगर बनाने के लिए आपके क्या सुझाव है ?

प्रतिमाह परिवार की स्वास्थ्य संबंधी समस्यायें एवं अन्य महत्वपूर्ण बातें, यदि हो :

जनवरी : रक्त रक्त के दौरान दिन चर्खे को निर्माण करने को बताया
2004 सभी का स्वास्थ्य सामान्य चल रहा है

फरवरी : दैनिक दिनचर्या निर्मित की जा रही है व्यायाम व्यवहार निर्माण करने
2004 का प्रयास जारी है स्वास्थ्य सामान्य है

मार्च : सभी का स्वास्थ्य ठीक है
2004

अप्रैल : सभी लोग परियोजना से काफी लाभान्वित हुये तथा इस परियोजना को आगे भी जारी रखने की सलाह दी।

मई :

जून :

जुलाई :

अगस्त :

सितम्बर :

अक्टूबर :

नवम्बर :

दिसंबर : सभी लाभ परियोजना का लाभ व उद्देश्य बताये।
2003

ANNEXURE No. 4.

IMPACT EVALUATION OF BEHAVIOUR INTERVENTION ON ILLNESS BREEDING BEHAVIOUR

(Schedule for Control Group)

Sponsored by

U P Health System Development Project
Lucknow

Conducted by

GIRI INSTITUTE OF DEVELOPMENT STUDIES
LUCKNOW

IMPACT EVALUATION OF BEHAVIOUR INTERVENTION ON ILLNESS BREEDING BEHAVIOUR

(SCHEDULE FOR CONTROLLED GROUP)

1.0 सामान्य सूचना :

1.1 जिला _____ 1.2 कस्बा _____

1.3 विकास खण्ड _____ 1.4 प्राथमिक स्वास्थ्य केन्द्र _____

1.5 ग्राम _____ 1.6 मोहल्ला _____

1.7 परिवार के मुखिया का नाम व पता _____

_____

1.8 जाति _____ 1.9 धर्म _____ 1.10 आयु _____

1.11 शैक्षिक स्तर _____ 1.12 वार्षिक आय (रू0) _____

1.13 परिवार का आर्थिक वर्ग

(अ) ग्रामीण (जोत आकार)

(i) 2 हेक्टेयर से कम (निम्न आय वर्ग) _____

(ii) 2 से 5 हेक्टेयर (मध्य आय वर्ग) _____

(iii) 6 हेक्टेयर और अधिक (उच्च आय वर्ग) _____

(ब) शहरीय (वार्षिक आय रू0 में)

(i) 20,000 से कम (निम्न आय वग।) _____

(ii) 20,000 से 1,00,000 (मध्य आय वग।) _____

(iii) 1,00,000 से अधिक (उच्च आय वग।) _____

2.0 परिवार की संरचना :

2.1 परिवार के सदस्यों की कुल संख्या _____

पुरूष _____

स्त्री _____

2.2 आयु वर्ग

5 वर्ष से कम _____

5 से 15 वर्ष तक _____

15 से 60 वर्ष तक _____

60 वर्ष से अधिक _____

2.3 परिवार के अन्य कार्यरत सदस्यों की संख्या _____

2.4 परिवार के अन्य कार्यरत सदस्यों की कुल वार्षिक आय (रू0) _____

3.0 **के0 जी0 एम0 यू0 के द्वारा किये गये इन्टरवेन्शन :**

3.1 क्या के0 जी0 एम0 यू0 के डाक्टर अथवा अन्य सदस्यों ने आपके परिवार से सम्पर्क किया था ?

हॉ ☐ नहीं ☐

3.2 यदि हॉ, तो उस समय क्या निम्नलिखित बातों पर चर्चा की थी ?

(अ) दैनिक रहन सहन हॉ ☐ नहीं ☐

यदि हॉ, तो किन बातों पर जोर दिया था ? _____

_____

(ब) स्वास्थ्य की देखभाल हॉ ☐ नहीं ☐

यदि हॉ, तो इस विषय पर क्या सलाह दी थी ? _____

_____

(स) स्वास्थ्य वर्धन हॉ ☐ नहीं ☐

यदि हॉ, तो स्वास्थ्यवर्धन के कौन से उपाय बताए थे ? _____

_____

3.3 क्या के0 जी0 एम0 यू0 के डा0 तथा अन्य सहयोगी आपसे मिले थे ? हॉ ☐ नहीं ☐ 3.

4 लगभग कितने लोग आये थे ?_____

3.5 कितनी बार के0 जी0 एम0 यू0 की टीम आयी थी ?

एक बार ☐

तीन चार बार ☐

कई बार ☐

3.6 क्या के0 जी0 एम0 यू0 ने सामुदायिक इन्टर्न और हैल्थ क्लब बनाए थे ?

हॉ ☐ नहीं ☐

3.7 यदि हॉ, तो सामुदायिक इन्टर्न की क्या भूमिका थी ? _____

_____

3.8 सामुदायिक इन्टर्न आपसे कब मिलते थे ?

रोजाना ☐

सप्ताह में ☐

महिने में ☐

तीन महिने में ☐

अन्य (विवरण दें) ☐

3.9 यदि हेल्थ क्लब बनाए थे तो इनमें किस तरह की गतिविधियॉ होती थी_____

_____

3.10 इन क्लबों की बैठक कब–कब होती थी ?

हर तीसरे दिन	☐
सप्ताह में एक बार	☐
कभी–कभी	☐
अन्य (विवरण) दे	☐

3.11 क्या आप हैल्थ क्लब की बैठकों में जाते थे ?

नियमित रूप से	☐
कभी–कभी	☐
अन्य (विवरण) दें	☐

3.12 यदि नहीं,जाते थे तो न जाने के कारण_____

_____

3.13 क्या आपके परिवार को सामुदायिक इन्टर्न तथा हेल्थ क्लब द्वारा निम्न प्रकार से स्वास्थ्य सम्बन्धी जानकारी होती रही ?

(i)	चार्ट अथवा पोस्टर	हॉ ☐	नहीं ☐
(ii)	प्रदर्शनी	हॉ ☐	नहीं ☐
(iii)	श्रव्य/ दृष्य साधन	हॉ ☐	नहीं ☐
(iv)	सामुदायिक सहभागिता	हॉ ☐	नहीं ☐
(v)	व्यक्तिगत सम्पर्क	हॉ ☐	नहीं ☐

3.14 यदि हॉ, तो क्या इन कार्य कलापों को आपने उपयोगी पाया ? हॉ ☐ नहीं ☐

3.15 क्या सामुदायिक इन्टर्न तथा हेल्थ क्लब अभी भी क्रियाशील है ? हॉ ☐ नहीं ☐

4.0 के0 जी0 एम0 यू0 द्वारा किये गये इन्टरवेन्शन का प्रभाव

4.1 इन्टरवेन्शन का आपके और परिवार के अन्य सदस्यों के दैनिक रहन–सहन पर किस तरह का असर हुआ ?

(i)	धूम्ररहित चूल्हा	हॉ ☐	नहीं ☐
(ii)	खाना पकाते समय स्वच्छता पर ध्यान देना	हॉ ☐	नहीं ☐
(iii)	घर को हवादार बनाना	हॉ ☐	नहीं ☐

(iv)	स्वच्छता तथा सफाई (घर तथा घर के चारो तरफ)	हॉ ☐	नहीं ☐
(v)	पौष्टिक आहार पर ध्यान	हॉ ☐	नहीं ☐
(vi)	व्यायाम	हॉ ☐	नहीं ☐
(vii)	नियमित दिनचर्या (समय पर उठने से सोने तक)	हॉ ☐	नहीं ☐
(viii)	स्वच्छ पेयजल	हॉ ☐	नहीं ☐
(ix)	परिवार में शान्त वातावरण को प्रोत्साहित करना	हॉ ☐	नहीं ☐
(x)	बुजुर्गो की देखभाल	हॉ ☐	नहीं ☐

यदि किसी भी पहलू पर उत्तर नहीं है तो उनके कारणों का उल्लेख करें। _____

4.2 इन्टरवेन्शन का स्वास्थ्य की देखभाल सम्बन्धित पहलुओं पर किस तरह का प्रभाव पड़ा ?

(i)	मौसमी बीमारियों के सम्बन्ध में ज्ञान	हॉ ☐	नहीं ☐
(ii)	बीमारी की स्थिति में सिर्फ योग्य चिकित्सकों से ही सम्पर्क करना	हॉ ☐	नहीं ☐
(iii)	बीमारी का इलाज तुरन्त ही करवाना	हॉ ☐	नहीं ☐
(iv)	अन्धविश्वासों से दूर रहना	हॉ ☐	नहीं ☐
(v)	एड्स के बारे में जानकारी	हॉ ☐	नहीं ☐
(vi)	परिवार नियोजन के सम्बन्ध में जानकारी	हॉ ☐	नहीं ☐
(vii)	नशा उन्मूलन सम्बन्धी जानकारी (शराब, सिगरेट/ बीड़ी, गांजा, भांग व अफीम आदि)	हॉ ☐	नहीं ☐
(viii)	तनाव मानसिक रोगों को जन्म देता है	हॉ ☐	नहीं ☐

यदि प्रभाव नहीं पड़ा तो कारणों का उल्लेख करिये _____

4.3 इन्टरवेन्शन का स्वास्थ्य वर्धन सम्बन्धी पहलुओं पर प्रभाव

(i)	क्या अब आपको स्वास्थ्य शिक्षा का ज्ञान है? (नियमित टीकारण, स्वास्थ्य परीक्षण आदि)	हॉ ☐	नहीं ☐
(ii)	स्वच्छ वातावरण की उपयोगिता	हॉ ☐	नहीं ☐
iii)	पौष्टिक आहार की आवश्यकता	हॉ ☐	नहीं ☐
(iv)	नियमित जीवन शैली	हॉ ☐	नहीं ☐

यदि प्रभाव नहीं पड़ा तो उसके कारणों का उल्लेख करिये _____

4.4 के0 जी0 एम0 यू0 द्वारा किये गये सभी इन्टरवेन्शन के फलस्वरूप क्या आपके और आपके परिवार के सदस्यों के स्वास्थ्य में सकारात्मक प्रभाव पड़ा है ?

हॉ ☐ नहीं ☐ कुछ हद तक ☐

4.5 के0 जी0 एम0 यू0 द्वारा दिये गये इन्टरवेन्शन में आपकी दृष्टि में सुधार किस तरह हो सकता है ?

_____

_____

5.0 <u>उत्तरदाता के विचार :</u>

5.1 के0 जी0 एम0 यू0 के इन्टरवेन्शन के पूर्व आप अपना या परिवार के सदस्यों का इलाज कहां करवाते थे?

(i) सरकारी (उपकेन्द्र, प्रा0 स्वा0 के0 इत्यादि) ☐

(ii) निजी (अस्पताल, नर्सिंग होम, क्लीनिक इत्यादि) ☐

(iii) घरेलू इलाज ☐

(iv) गांव/मोहल्ले के वैद्य/हकीम ☐

(v) झोला छाप डाक्टर ☐

(vi) झाड़ फूंक ☐

(vii) अन्य (उल्लेख करें) _____

5.2 के0 जी0 एम0 यू0 द्वारा दिये गये इन्टरवेन्शन के पश्चात अब आप अपना या परिवार के सदस्यों का इलाज कहां करवाते हैं ?

(i) सरकारी (उपकेन्द्र, प्रा0 स्वा0 के0 इत्यादि) ☐

(ii) निजी (अस्पताल, नर्सिंग होम, क्लीनिक इत्यादि) ☐

(iii) घरेलू इलाज ☐

(iv) गांव/मोहल्ले के वैद्य/हकीम ☐

(v) झोला छाप डाक्टर ☐

(vi) झाड़ फूंक ☐

(vii) अन्य (उल्लेख करें) _____

5.3 क्या सरकारी अस्पताल में मिलने वाली चिकित्सकीय सुविधाएं संतोषजनक हैं ?

हॉ ☐ नहीं ☐

5.4 यदि नहीं, तो किन सुविधाओं की कमी है_____

5.5 ए0 एन0 एम0/ स्वास्थ्य कर्मी जो पहले से ही कार्यरत थे उनकी अपेक्षा के0 जी0 एन0 यू0 द्वारा चयनित सामुदायिक इन्टर्न के बीच क्या आपने अन्तर पाया ?

हॉ ☐ नहीं ☐

5.6 यदि हॉ, तो किस तरह का अन्तर पाया ?

ए0 एन0 एम0 /स्वास्थ्यकर्मी ज्यादा अच्छे ☐

सामुदायिक इन्टर्न अधिक प्रभावशाली ☐

उल्लेख करें _____

_____

5.7 क्या आपकी दृष्टि में इस तरह के इन्टरवेन्शन समय–समय पर होते रहने चाहिए ?

हॉ ☐ नहीं ☐

ANNEXURE No 5.

IMPACT EVALUATION OF BEHAVIOUR INTERVENTION ON ILLNESS BREEDING BEHAVIOUR

(Schedule for Uncontrol Group)

Sponsored by

U P Health System Development Project
Lucknow

Conducted by

GIRI INSTITUTE OF DEVELOPMENT STUDIES
LUCKNOW

IMPACT EVALUATION OF BEHAVIOUR INTERVENTION ON ILLNESS BREEDING BEHAVIOUR

(SCHEDULE FOR UN-CONTROLLED GROUP)

1.0 सामान्य सूचना

1.1 जिला .....1.2 विकास खण्ड .....

1.3 प्राथमिक स्वास्थ्य केन्द्र ..... 1.4 कस्बा .....

1.5 मोहल्ला ..... 1.6 ग्राम .....

1.7 परिवार के मुखिया का नाम व पता .....

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1.8 जाति ..... 1.9 धर्म .....1-10 आयु.....

1.11 शैक्षिक स्तर ..... 1.12 वार्षिक आय (रू०) .....

1.13 परिवार का आर्थिक वर्ग

(अ) ग्रामीण (जोतों का आकार)

(i) 2 हेक्टेयर से कम (निम्न आय वर्ग) .....

(ii) 2 से 5 हेक्टेयर (मध्य आय वर्ग) .....

(iii) 6 हेक्टेयर और अधिक (उच्च आय वर्ग) .....

(ब) शहरीय (कुल वार्षिक आय रू० में)

(i) 20,000 से कम (निम्न आय वर्ग) .....

(ii) 20,000 से 1,00,000 तक (मध्य आय वर्ग).....

(iii) 1,00,000 से अधिक (उच्च आय वर्ग) .....

2.0 परिवार की संरचना

2.1 परिवार के सदस्यों की कुल संख्या .....

पुरूष .....

स्त्री .....

2.2 आयु वर्ग 5 वर्ष से कम .....

5 वर्ष से 15 वर्ष तक .....

15 वर्ष से 60 वर्ष तक .....

60 वर्ष से अधिक .....

2.3 परिवार के अन्य कार्यरत सदस्यों की संख्या .....

2.4 परिवार के अन्य कार्यरत सदस्यों की कुल वार्षिक आय (रू०).....

3.0 <u>स्वच्छता, सामान्य रहन–सहन एवं स्वास्थवर्धन सम्बन्धी जानकारी</u>

3.1 क्या आप निम्नलिखित बातों का ध्यान रखते हैं और उन पर ध्यान देते हैं –

(i) रसोईघर धूम्र रहित होना चाहिए हॉ ☐ नही ☐

(ii) खाना पकाते समय स्वच्छता आवश्यक है हॉ ☐ नहीं ☐

(iii) घर तथा घर के आसपास सफाई आवश्यक है हॉ ☐ नहीं ☐

(iv) हमें स्वयं को भी स्वच्छ रखना चाहिए (हाथ धोना, दांतों की सफाई, नहाना इत्यादि) हॉ ☐ नहीं ☐

(v) हमें अपने घर को हवादार बनाना चाहिए हॉ ☐ नहीं ☐

(vi) हमें संतुलित भोजन लेना चाहिए हॉ ☐ नहीं ☐

(vii) पीने के लिए स्वच्छ पेयजल होना चाहिए हॉ ☐ नहीं ☐

3.2 यदि 3.1 के प्रश्नों का उत्तर हॉ में है तो इन चीजों का ज्ञान आपको कहॉ से प्राप्त हुआ?

पारिवारिक सदस्य ☐ स्वास्थ्य कर्मी से ☐

संचार माध्यमों से ☐ स्वैच्छिक संस्थाओं से ☐

अन्य (उल्लेख करें) .....

3.3 क्या आपको स्वास्थ्य सम्बन्धी निम्नलिखित जानकारी है ?

(i) बीमारी होते ही बीमारी का तुरन्त इलाज करना चाहिए हॉ ☐ नहीं ☐

(ii) हमेशा योग्य डाक्टर से ही इलाज करवाना चाहिए हॉ ☐ नहीं ☐

(iii) एड्स के बारे में ज्ञान हॉ ☐ नहीं ☐

(iv) परिवार नियोजन के सम्बन्ध में जानकारी हॉ ☐ नहीं ☐

(v) स्वास्थ्य के लिए व्यायाम आवश्यक है हॉ ☐ नहीं ☐

(vi) मानसिक तनाव से बीमारी होने के सम्बन्ध में ज्ञान हॉ ☐ नहीं ☐

(vii) किसी भी तरह का नशा स्वास्थ्य के लिए हानिकारक है हॉ ☐ नहीं ☐

3.4 यदि 3.3 प्रश्न का उत्तर 'हॉ' है तो इन बातों की जानकारी आपको कहॉ से हुई?

पारिवारिक सदस्य ☐ स्वास्थ्य कर्मी ☐

संचार माध्यम ☐ स्वैच्छिक संस्था ☐

अन्य (उल्लेख करें) .....

3.5 क्या 3.3 में पूछी हुई बातों के विषय में ज्ञान रखने के साथ–साथ आप इन बातों का व्यावहारिक जीवन में उपयोग करते हैं? हॉ ☐ नहीं ☐

3.6 यदि नहीं तो क्यों नहीं करते ?

.....

4.0 <u>के० जी० एम० यू० द्वारा चलाये गये व्यावहारिक इन्टरवेन्शन की जानकारी</u>

4.1 आपके गॉव/मोहल्ले में जो व्यावहारिक इन्टरवेन्शन किये गये थे क्या आपको उनके बारे में जानकारी हैं?

हॉ ☐ नहीं ☐

4.2 यदि हॉ तो के० जी० एम० यू० के द्वारा कौन–कौन से इन्टरवेन्शन किये गये थे ?

(i) रहन–सहन सम्बन्धी ☐

(ii) स्वास्थ्य की देखभाल सम्बन्धी ☐

(iii) स्वास्थ्य वर्धन सम्बन्धी ☐

4.3 क्या आपके विचार में यह इन्टरवेन्शन उपयोगी था ? हॉ ☐ नहीं ☐

4.4 यदि इन्टरवेन्शन उपयोगी था तो क्या आप भी उससे लाभान्वित हो रहे हैं ?

हॉ ☐ नहीं ☐

4.5 के० जी० एम० यू० द्वारा नियुक्त किये सामुदायिक इन्टर्न तथा स्वास्थ्य क्लब के बारे में आपको जानकारी हैं।

हॉ ☐ नहीं ☐

4.6 यदि हॉ तो इनके बारे में आपके क्या विचार हैं ?

बहुत अच्छे ☐ अच्छे ☐ सामान्य ☐ कोई खास नहीं ☐

5.0 <u>वर्तमान में ली जा रही स्वास्थ्य सेवाओं के बारे में उत्तरदाता के विचार</u>

5.1 साधारणतया आप सामान्य व जटिल बीमारियों के इलाज के लिए कहॉ जाते हैं ?

सरकारी अस्पताल ☐ निजी अस्पताल/क्लिनिक ☐

वैद्य/हकीम ☐ घरेलू इलाज ☐

झोला छाप डाक्टर ☐ झाड़–फूंक ☐

5.2 क्या आप सरकारी संस्थाओं के माध्यम से दी जा रही स्वास्थ्य सेवाओं से संतुष्ट हैं

हॉ ☐ नहीं ☐

5.3 यदि नही तो सरकारी स्वास्थ्य सेवाओं में क्या कमी है? .....

.....

ANNEXURE No. 6.

Points for Discussions with Community Interns

1. Name _____ 2. District _____
3. Village/Mohalla _____ 4. Age (Years) _____
5. Education Qualifications _____
6. Through whom did the KGMU approach you for selecting you as a Community Intern?
   _____
7. Did they train you after your selection as a Community Intern? Yes ☐ No ☐

   If Yes, duration of training (days) _____

   Was this duration sufficient? Yes ☐ No ☐
8. What duties were assigned to you?
   _____
   _____
9. Were you asked to keep regular contact with the control group? Yes ☐ No ☐
10. If yes the frequency of your visit: _____
11. How many households were under your charge? _____
12. Were you given any payment for the services provided by you? Yes ☐ No ☐
13. If yes, how much? _____
14. Who formed the Health Club? Community Interns ☐ KGMU ☐
15. Who were its members and the number of households in each club? _____
16. What were the functions of the Health Club?
    _____
    _____
17. What type of help was provided by the KGMU for the Health Club?

    (a) Monetary Help ☐ (b) Posters/Display materials ☐

    (c) Audio/Video publicity material ☐ (d) Any other (lecture by KGMU Team etc ☐
18. Did the KGMU team spend time with you to visit the selected households and the Health Clubs? Yes ☐ No ☐
19. If yes, how many visits were made by the KGMU Team? _____
20. How many members were in the KGMU research team? _____
21. How good was the team? _____

22. Was the IEC material which was developed by the KGMU good? Yes ☐ No ☐

23. Where and how was it utilized?

_____

_____

24. In your opinion what was the impact of the Intervention on the selected households in the following areas?

(a) Daily Living: Very Effective ☐ Effective ☐ Not very effective ☐

(b) Health Care: Very Effective ☐ Effective ☐ Not very effective ☐

(c) Health Promotion: Very Effective ☐ Effective ☐ Not very effective ☐

25. In case the Intervention was not effective, what were the reasons?

_____

_____

26. In case Intervention was not effective what should have been done to make it more effective?

_____

_____

27. Do you continue to motivate the households and run the Health Club even after the KGMU project is over?

Yes ☐ No ☐

28. If No, reasons for not doing so?

_____

_____

29. Do you feel that such interventions need to be carried out at regular intervals?

Yes ☐ No ☐

ANNEXURE No. 7

Points for Discussions with Village Pradhan and NGOs

1. Did the KGMU team meet you before they began their Intervention? Yes ☐ No ☐
2. If Yes, in what connection?

   _____

   _____
3. How many members were in the team? _____
4. How long did they stay in the village/mohalla? _____
5. What type of intervention was done by them?

   _____

   _____
6. Did they take your help in selecting Community Interns? Yes ☐ No ☐
7. Do you think the right persons were selected as Community Interns? Ye ☐ No ☐
8. If No, what was wrong in their selection?

   _____

   _____
9. What was the work of the Community Interns?

   _____

   _____
10. What were the activities of the Health Clubs?

    _____

    _____
11. How regularly did the KGMU team, the Community Interns and Health Clubs meet with the selected households?

    (a) KGMU team _____

    (b) Community Interns _____

    (c) Health Clubs _____
12. Did KGMU team/Community Intern/or Health Clubs display any posters or any other IEC material for improving the living conditions, improving health care and improving health promotion among the households selected for Intervention?

    Yes ☐ No ☐
13. If Yes, were these IEC materials useful? Yes ☐ No ☐
14. Do you feel that the intervention has brought about improvements in the selected households in the following areas:

    (a) Living Conditions Yes ☐ No ☐

    (b) Health Care Yes ☐ No ☐

    (c) Health Promotion Yes ☐ No ☐

15. If Yes, to what extent?

(a) Living Conditions:	Considerable Improvement ☐	Slight Improvement ☐
(b) Health Care:	Considerable Improvement ☐	Slight Improvement ☐
(c) Health Promotion:	Considerable Improvement ☐	Slight Improvement ☐

16. If No, why?

_____

_____

17. Are the Community Interns and Health Clubs still active in your village/mohalla or did they stop functioning after the KGMU intervention was over?

Yes ☐ No ☐

ANNEXURE No. 8

Points for Discussions with the Doctor at the PHC

1. Did the KGMU team approach you before and during the conduct of their behaviour intervention? Yes ☐ No ☐
2. Did they ask you for any type of help in the conduct of their study? Yes ☐ No ☐
3. How many persons were in the team? _____
4. Do you know what type of intervention was conducted by them?
   _____
5. Are you aware that they selected Community Interns and formed Health Club? Yes ☐ No ☐
6. If Yes, what were the functions of the Community Interns and Health Club?
   (a) Community Interns _____
   (b) Health Clubs _____
7. Do you think that the idea of making Community Interns and Health Clubs was a good idea? Yes ☐ No ☐
8. Since the health system already has ANM's and health workers what extra work can be expected from the Community Interns?
   _____
   _____
9. The KGMU team prepared some IEC materials (Posters, etc.). Did you see the same? Yes ☐ No ☐
10. If Yes, how was the IEC material used by the KGMU team or the Community Interns?
    _____
    _____
11. In your opinion did the KGMU team did the Intervention work effectively? Yes ☐ No ☐
12. In what way did it have an impact on the household where the Intervention was conducted?
    (a) Proved useful in improving living conditions ☐
    (b) Proved useful in improving health care ☐
    (c) Proved useful in improving health promotion ☐
    (d) Useful in all three areas ☐
    (e) Did not serve any purpose ☐
13. Are the Community Interns and Health Clubs still working? Yes ☐ No ☐
14. Did the KGMU utilize your services in the Intervention? Yes ☐ No ☐
15. If Yes, in which way?
    _____
16. Did the KGMU team refer any cases from among their selected households to you for treatment while their Intervention was in progress? Yes ☐ No ☐